Michael D. Doty, DDS
699 McBroom Street NW, Suite C; Abingdon, VA 24210
276-628-6251

PATIENT REGISTRATION

Patient's Name____ Preferred Name____________________
First Last M.I.

Street Address ____________________City ________________ State ________ Zip ____________

Home Phone ______________ Cell Phone____________________ E-Mail__________________________

Can we email or text you appointment reminders? Y N Marital Status: Single ____Married ____ Divorced____ Separated____ Widowed ____

Date of Birth____________________ Age____ Social Security No.____________________ Male ____ Female________

Employer ______________________________ Work Phone ______________Extension:______________

Emergency Contact ________________________Phone________________Relationship______________

Whom may we thank for this referral?____

Responsible Party information (if different from above):

Name____________________Address______________City____________State ____Zip________

Social Security No.______________________________ Date of Birth__________________________

Employer ______________________________________ Work Phone__________________________

Dental Insurance Information:

Subscriber Name ______________________________ Employer______________________________

Policy # ______________Social Security #______________Date of Birth____________________

Consent:

I consent to the diagnostic procedures and treatment by the dentist as necessary for proper dental care. By signing below I acknowledge that I have received and reviewed a copy of Notice of Privacy Practices and I consent to the dentist's use and disclosure of my records (or my child's records) to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment.

I consent to the disclosure of my records (or my child's records) to the following persons who are involved in my care (or my child's care) or payment for that care. My consent to disclosure of records shall be effective until I revoke it in writing.

I understand that PAYMENT IS DUE IN FULL AT EACH VISIT. If insurance applies, I authorize payment directly to the dentist or dental group of insurance benefits. I understand that my dental care insurance carrier may pay less than the actual bill for services, and that I am financially responsible for payment in full of all accounts *at time of service*. By signing this statement, I agree to be responsible for payment of services not paid by my dental care payer.

I HAVE READ AND AGREED TO ABIDE BY ALL WRITTEN OFFICE POLICIES:

PATIENT'S OR GUARDIAN'S SIGNATURE__________________________________**Date**__________________

PLEASE NOTE THAT ALL FEES ARE DUE AT THE TIME OF SERVICE