Larry Lee Chabot, D.D.S.

Patient Registration

Patient Information

Date _____

Patient's Name _____ (Last) _____ (First) _____ (Middle)

Address _____ (Street) _____ (City) _____ (State) _____ (Zip)

Home Phone _____ Birthdate _____ Age _____ Social Security # _____

Cell Phone _____ Work Phone _____

Sex: M or F Maritial Status _____ Are you a full time student? _____

If patient is a minor, give parent's or guardian's name _____

Whom may we thank for referring you to our office? _____

Email Address _____

Responsible Party Information

Name _____ (Last) _____ (First) _____ (Middle) _____ (Marital Status)

Residence _____ (Home Street Address) _____ (City) _____ (State) _____ (Zip)

Mailing Address _____ (Street) _____ (City) _____ (State) _____ (Zip)

Home Phone _____ Cell Phone _____

Driver's License _____ Social Security _____

Birthdate _____ Relationship to Patient _____

Employer _____ Work Phone _____

Insurance Information

Insured's Name _____ Insured's Soc. Sec.# _____

Insurance Company _____ Group No. _____ ID# _____

Insurance Co. Address _____

Insurance Telephone # _____ Insured's Employer _____

Do you have double coverage ❑ Yes ❑ No If yes, complete the following: _____

Insured's Name _____ Insured's Soc. Sec.# _____

Insurance Company _____ Group No. _____ ID# _____

Insurance Co. Address _____

Insurance Telephone # _____ Insured's Employer _____

Local Emergency Contact

Name _____ Relationship _____

Phone _____

CONSENT: The undersigned hereby authorizes Office Staff to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Office Staff to perform any and all forms of treatment, mdication, and therapy, that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, the undersigned, due and payable at the time services are rendered. I also assign all insurance benefits to the Doctor.

PATIENT SIGNATURE (Parent or Guardian of Child) _____ Date: _____ Reviewed by: _____