M.G. Radi, D.D.S.
1004 Riley Street, Suite 5 • Folsom, CA 95630
(916) 985-3366

PATIENT REGISTRATION

Tell Us About The Patient
Name
Mailing Address
City
State Zip
Email Address
Home Phone ( )
Cell Phone ( )
Work Phone ( )
Birthday
Social Security Number
Employer
Employer Address
Employer City
Employer Phone
Spouse's Name
Gender ❑ Male ❑ Female

Insured/Responsible Party
Name
Mailing Address
City
State Zip
Email Address
Home Phone ( )
Cell Phone ( )
Work Phone ( )
Birthday
Social Security Number
Employer
Employer Address
Employer City
Employer Phone
Spouse's Name
Relationship to Patient

Would you prefer to be contacted via email? ❑ Yes ❑ No

If You Have Insurance, Please Fill In This Box

Primary Insurance
Insurance Carrier
Group#

Secondary Insurance
Insurance Carrier
Group#

Do others in your family come here? ❑ Yes ❑ No Name(s)_____

_____

_____

Person to contact for an emergency: Telephone ( ) _____

Relationship to patient_____

How were you referred to our office? (please check one)

- ❑ I have been a patient of the office _____
- ❑ By another patient/friend (name)_____
- ❑ Yellow Pages (which book) _____
- ❑ Saw building/sign
- ❑ By my insurance company
- ❑ By my doctor (name)_____
- ❑ Other _____

PLEASE TURN PAGE OVER TO COMPLETE

I authorize any doctor or staff to take x-rays, diagnostic models, photographs and other diagnostic aids deemed appropriate to make a diagnosis of the patient's needs. I authorize the doctors and staff to release information for the purposes of diagnosis, treatment, medical evaluation, peer review, educational purposes, billing of charges, legal and collection actions.
I authorized the doctors or staff to perform all mutually agreeable treatments utilizing such assistance as the doctor deems necessary.
I agree to the use of anesthetics or other medications as necessary for my treatment. I fully understand that using medications has certain risks; a full recital of which will be presented if requested.

I understand that I am responsible for all charges incurred for my treatment or for the patient for whom I am the responsible party regardless of any insurance coverage. **Payment for services is due at the time of service. If payment is not received, a fiance charge of 1.5% per month (minimum $.50) may be added to my account for balances older than 120 days.**

Please indicate your preferred method of payment:
(We offer monthly payments that carry low monthly payments, no annual fees, and do not add to your existing credit card balances.)

- ❑ Cash
- ❑ Check
- ❑ Credit Card
- ❑ Care Credit

Privacy Notice

I have received this office's Notice of Privacy Practices as required by law.

Dental Materials Notice

I have received the State of California DENTAL MATERIALS FACT SHEET as required by law.

Patient's name (printed please)_____

Responsible party's **Signature**_____Date _____