Fred Keyser, III, DDS, PLLC
Comprehensive, Restorative, Cosmetic Dentistry

Patient Registration
Please complete the following confidential information

Please complete the following confidential information:
Date: ____
Name: ____
Preferred Name: ____
Social Security Number: ____
Address: ____
City/State/Zip: ____
Phone: ____
Cell: ____
Email: ____
Birthdate: ____
__Married __Single __Divorced __ Separated

Getting to know you
Is another member of your family a patient?
Name: ____ Relationship: ____
Who referred you? ____
Emergency Contact: ____
Phone: ____
Address: ____
City/State/Zip: ____
Closest Relative not living with you: ____
Phone: ____
Address: ____
City/State/Zip: ____

Account Information:
Responsible party: ____
Relationship to patient: ____
Social Security Number: ____
Address: ____
City/State/Zip: ____
Phone: ____

Personal Occupation: ____
Employer: ____
Employer Address: ____
City/State/Zip: ____
Phone: ____

Spouse's Name: ____
Occupation: ____
Employer: ____
Employer Address: ____
City/State/Zip: ____
Phone: ____

- I hereby authorize Dr.Keyser or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by Dr. Keyser to make a thorough diagnosis

-Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care

-I agree to the use of anesthetics, sedatives, and other medication as necessary. I fully understand that using these agents and undergoing dental treatment embodies certain risks. I understand that I can ask for a complete recital of The Risks of General Dentistry

-I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payments are due at the time of service unless other arrangements have been made.

Patient's Signature: ____ Date: ____
Witness Signature: ____
Parent/Responsible Party Signature: ____
Relationship to Patient: