R. CARSON KIGHT, DMD
DISTINCTIVE DENTISTRY

WELCOME!

We are very happy to have you and your loved ones join our fine family of patients!

Date:

ABOUT YOU

Name: _____

Preferred name: _____ ☐ Male ☐ Female

DOB: _____ Age: _____ SS#: _____ ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Street Address: _____ City: _____ State: _____ ZIP _____

Mailing Address: _____ City: _____ State: _____ ZIP _____

Home phone: _____ Work Phone: _____ Ext.: _____

Mobile phone: _____ Email: _____

Employer: _____ Address: _____

Years there: _____ Occupation: _____

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

ABOUT YOUR SPOUSE

Name: _____

DOB: _____ Age: _____ SS#: _____

Employer: _____ Occupation: _____

Work phone: _____ Mobile: _____

PERSON RESPONSIBLE FOR YOUR ACCOUNT

Name: _____ Relationship to you: _____

EMERGENCY CONTACT INFORMATION

In the case of an emergency, is there someone we could contact? ☐ Spouse ☐ Other: _____

Home phone: _____ Work phone: _____ Mobile phone: _____

PLEASE READ TO FOLLOWING CAREFULLY

• I authorized release of any information concerning my health care, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits. • I authorize payment of insurance benefits directly to R. Carson Kight, D.M.D., otherwise payable to me. • I authorize release of any information concerning my health care, advice, and treatment to another dentist, physician, or other healthcare provider. • I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services. I understand that I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part, by my dental care insurance payor. • I authorize Dr. R. Carson Kight and her staff, with informed consent, to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. • The information on this page and the medical/dental histories to be provided are true and correct to the best of my knowledge. I also understand that all information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical/dental status and/or the information contained on this registration form.

Signature: _____ Date: _____

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