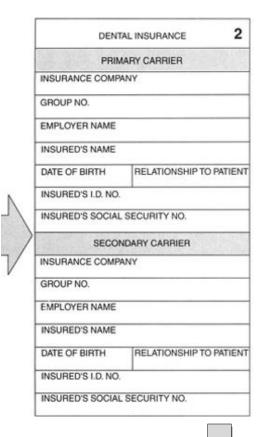
CHRISTY SAVAS, DDS.

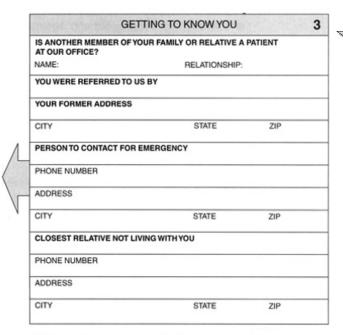
PATIENT REGISTRATION

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

	DATE					
٨	LAST NAME	FIRST		M.I.		
	PREFERS TO BE CALLED BY					
HIS	ADDRESS					
FTHIS APPOINTMENT IS FOR YOUR CHILD START HERE	CITY		STATE	ZIP		
	HOME PHONE NO.		FAX	FAX		
	CELL		EMAIL			
	BIRTHDATE	AGE	MALE	FEMALE		
	MARRIED	SINGLE	DIVORCED	WIDOWED		
	SOCIAL SECURITY NO.					
	DATE					
	LAST NAME	FIRST		M.I.		
	ADDRESS					
	CITY		STATE	ZIP		
	HOME PHONE NO.					
	BIRTHDATE	AGE	MALE	FEMALE		
	SCHOOL			GRADE		
	SOCIAL SECURITY NO.					



ACCOUNT INFORMATION					
PERSON FINANCIALLY I	RESPONSIBLE FOR ACCOUNT				
NAME					
RELATIONSHIP TO PATIENT	SOCIAL SECURITY NO.				
ADDRESS					
CITY	STATE ZIP				
PHONE NO.					
YOU					
NAME					
OCCUPATION					
EMPLOYER'S NAME					
ADDRESS	CITY				
PHONE NO.	FAX NO.				
YOUR SPOUSE					
NAME					
OCCUPATION					
EMPLOYER'S NAME					
ADDRESS	CITY				
PHONE NO.	FAX NO.				



Please turn over and sign

CHRISTY SAVAS, DDS.

CONSENT FOR TREATMENT

1.	I hereby authorize doctor or desi diagnostic aids deemed appropri patient)	ate by doctor to make a	thorough diagnosis of (name of			
2.	_	-	octor to perform all recommended treatment mutually agreed istance as required to provide proper care.			
3.		sedatives and other medication as necessary. I fully understands odies certain risks. I understand that I can ask for a complete cions.				
4.	electronica health records that ar my treatment, payment and healt information necessary to provide	ctor's or designated staff's use and disclosure of any oral, written or ds that are individually identifiable as mine for the purpose of carrying out and health care operations. I understand that only the minimum amount of o provide quality care will be used or disclosed and that a notice fully of my personal health information is available.				
5.	5. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made In the event payments are not received by agreed upon dates, I understand that a 1-1/2% late charge (18% APR) may be added to my account. If required, I also understand a check of my credit history may be made.					
Patient	Signature:	Date:	Witness			

Parent/ Responsible Party's Signature: ______ Relationship to Patient: _____