5336 Stadium Trace Parkway
Suite 112
Birmingham, AL 35244

REGISTRATION

Patient's name:				Date of Birth:
Age:	Sex:	SS #	Race:	Marital Status:
Address:				
City:		State:	Zip:	
Home Phone:		Work Phone:		Cell Phone:
Father/Husband:			Mother/Wife:	
Patient's Dentist:			Patient's Physician:	
Do you know a patient of ours?				
Who referred you to our office?				
What problem may we help you with?				

RESPONSIBLE PARTY

Person responsible for payment fees: (Person bringing child is responsible for payment)				
Address (If different from above)				
City:		State:	Zip:	
Home Phone:		Work Phone:		Cell phone:
Email Address:				
Responsible person's employer			Position:	
Employer's address				
Responsible person's Birthdate:			SS#	
Spouses's Employer:			Position:	
Employer's address				

INSURANCE

Orthodontic Insurance Company:				
Policy #			Group #	
Major Medical (for TMJ treatment only)				
Policy #			Group #	

RELEASE OF MEDICAL INFORMATION AND FINANCIAL RESPONSIBILITY

I, the undersigned, hereby authorize release of any or all medical records to the referring physicians or dentists, my insurance carriers, or those involved in payment of my account. I further acknowledge full financial responsibility for any services rendered by Dr. Stephanie B. Whitehead and understand that payment of charges incurred in the office is due at the time of service. In the event that an account is not paid within 90 days, the undersigned agrees to pay all costs of collection including attorney's fees and hereby waives the right of exemption under the Constitution of the State of Alabama.

Date: Signature: