

SCOTT MORRIS DDS & ASSOCIATES, P.C. PATIENT REGISTRATION

Patient Information

First Name: Last Name: Middle Initial:
Address: City, State, Zip:
Cellular: Home #: Work#:
Birth Date: Soc Sec: Drivers Lic:
Sex: Male Female Marital Status: Child Single Married Divorced Separated Widowed
Emergency Contact Name: Emergency Contact #:
Whom may we thank for referring you to us?
Do you have a preferred nick name:

Responsible Party (if patient is a minor or has a guardian)

First Name: Last Name: Middle Initial:
Address: City, State, Zip:
Cellular: Home #: Work#:
Birth Date: Soc Sec: Drivers Lic:
Sex: Male Female Marital Status: Child Single Married Divorced Separated Widowed
Relationship to patient: Self Spouse Child Other

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN DATE

Patient Message Consent

I consent to Scott Morris DDS & Associates P.C. contacting me electronically for the purpose of appointment reminders, oral health promotion, notification that I need to make an appointment or reminders of uncompleted treatment.

I acknowledge that phone, text, instant messaging, and email messaging is a complimentary service and that these may not take place on all occasions. It is ultimately my responsibility to attend appointments or notify the office within 48 hours of any rescheduling or cancellation of my appointment.

I understand that during the transmission of these messages, the information contained at one point or another may pass through a public network and onto a personal electronic device and as such the transmission may not be secure. However, the practice will not transmit any personal or confidential information about your health, procedures, or account status with our practice.

I agree to inform the practice if contact information such as email address or cell phone number have changed. I understand and acknowledge that I can cancel this consent form at any time.

Please indicate which methods of communication are acceptable to you:

- Text Messages Instant Messaging FaceBook
Email Email Address:
Other
I do not wish to be contacted in any of the forms listed above.

(Patient or Guardian Signature) Date

Your information will not be shared with anyone else.