PAUL A. KLOEK, DDS
W7154 Green Valley Road
Spooner, WI 54801
Phone 715-635-7888
www.greenvalleydentalcare.com

PATIENT REGISTRATION

Patient Name: _____ **DOB:**

For those patients with secondary dental insurance, please complete the following:
Secondary Dental Insurance: **Group/Plan Name:**

Policy Holder: _____ _____ _____
First Name Last Name Date of Birth Relationship to Patient

Insurance Co Address:
Street City /State/Zip

Plan ID# (or policy holder SSN): _____ Group #_____
Additional family members under this plan: _____

Parent/Guardian/Caregiver Information
Name: _____ Date of Birth:_____/_____/_____
First Last

Address (if different than patient):

_____ _____ _____ _____
Street City State Zip

Contact Number(s) if Different than Patient: Home: _____ Cell: _____
If you are a caregiver, are you also Power of Attorney? □ Yes □ No

Consent for Care of Minors (age 17 and younger)

- I consent to the diagnostic procedures and treatment by the dentist necessary for my child's proper dental care. I consent to the dentist's use and disclosure of my child's records to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment.
- **Other than parent(s)/guardian(s) -I consent to the disclosure of my child's records to the following persons who are involved in my child's care, or payment for that care. I consent to the following person(s) bringing my child to their dental appointment(s):**
  Name: _____Relationship_____
  Name: _____Relationship_____
- My consent to disclosure of records shall be effective until I revoke it in writing. I authorize payment directly to **Green Valley Dental Care** of insurance benefits otherwise payable to me. I understand that my dental insurance carrier, or payor of my dental benefits, may pay less than the actual bill for services, and 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, by my dental care payor.
- I consent for Green Valley Dental Care to treat my minor child, even if I am not present. Treatment may include, but is not limited to, dental cleanings, dental exams, fillings, administering of Nitrous Oxide relaxing gas and/or extractions. This consent is valid unless revoked by me, in writing, to Green Valley Dental Care.

Parent/Guardian Signature: _____ **Date**: _____