PATIENT REGISTRATION

PATIENT INFORMATION: Please fill out ALL information clearly and accurately.

Date: _____________ Email ____ Best Contact #: ( ) ______________
Name: ____ Sex ______ Cell Contact #: ( ) _______________
Address: ____ Home Phone: ( ) ________________
City: ________________________________ State: ________ Zip ______________ Work Phone ( ) ________________
Birthdate: ______________ SSN ________-______-________ Okay To Call Work: □Yes □No
Marital Status: □ Single □Married □Divorced □Separated □Child Driver's License Number____________________ State ______
Employer: ____ Employer's Address _________________________________
In case of emergency, contact: ______________________________ Relation: ______________ Phone ( ) ________________
Referred By: ____ Reason for visit: ____________________________________

PRIMARY INSURANCE INFORMATION:

PRIMARY Insurance Plan Name: ____ Phone Number: ____________________
Name of Insured: _________________________________ D.O.B. _________________ SSN: _______-_______-_______
Policy #: ____________________________ Group #: ____________________ Relationship to Insured: □Self □Spouse □Child □Other
Insured's Address: ____ Phone Number: ____________________
Insured's Employer: ____ Address: _________________________________

SECONDARY INSURANCE INFORMATION:

SECONDARY Insurance Plan Name: ____ Phone Number: ____________________
Name of Insured: _________________________________ D.O.B. _________________ SSN: _______-_______-_______
Policy #: ____________________________ Group #: ____________________ Relationship to Insured: □Self □Spouse □Child □Other
Insured's Address: ____ Phone Number: ____________________
Insured's Employer: ____ Address: _________________________________

Thank you for choosing our office as our health care provider! We are committed to providing you with the highest quality lifetime dental care, so that you may attain optimum oral health. The following is a statement of our financial policy, which we require that you read, agree to, and sign prior to any treatment. Please note that payment of your bill is considered part of your treatment. Payment is due at the time services are rendered. Our office accepts cash, checks, MasterCard, Visa and Discover. Outside financing is available upon request and approval.

Please note: Returned checks will be subject to additional fees. In the case it becomes necessary for our office to enlist a collection service and/or legal assistance; you will be responsible for any collection and/or legal charge up to 35%.

Do You Have Insurance?

- As a courtesy to you we will help you process all of your insurance claims. Please understand that we will provide an insurance estimate to you, however it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits ultimately determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible.
- All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company. Our office is not a party to the contract.
- Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for your area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.
- We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office.
- We ask that you pay the deductible and co-payment, which is the estimated amount not covered by your insurance company, by cash, checks, MasterCard, Visa or Discover at the time we provide the service to you.
- Insurance payments are ordinarily received within 30-60 days from the time of filing. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not resolved or your claim is denied, you will be responsible for paying the full amount at that time.
- We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being pid. Our office will not, however, enter into a dispute with your insurance company over any claim.

Thank you for the opportunity to serve your dental health care needs and we welcome any questions you may have concerning your care or our financial policy.

I HAVE READ , UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO MY DENTAL OFFICE. I understand that payment for Dental Services provided in this office for myself or my dependents would be my responsibility. Payments are due at the time services are rendered unless previous financial arrangements have been made. I further understand that a finance, rebilling, collection fee or attorney fee will be added to any overdue balance.

By signing below, you are authorizing us to call you at any number you provide including calls to mobile/cellular or similar devices for any lawful purpose. You agree to fees or charges that you may incur from an incoming call from us, and/or outgoing calls to us, to or from any such number, without reimbursement from us.

Patient / Parent / Guardian Signature: ____ Date: __________________
Doctor Signature: ____ Date: __________________