PATIENT REGISTRATION

Today's Date _____

Patient's Name _____ Sex: M F Date of Birth _____ Age _____

Home Address _____ City _____ State _____ ZIP _____

Please Circle One: Single Married Separated Divorced Widowed Patient Soc. Sec. # _____

Home Phone # _____ Cell Phone # _____ E-mail Address _____

Your Employer _____ Work Phone # _____ How Long Employed _____

Are you a full-time student? Yes No If patient is a minor we need: Mother's DOB _____ Father's DOB _____

Person responsible for account _____ Driver's License # _____ Relationship _____

Name of spouse (parent if minor) _____ Spouse's (parent's) Soc. Sec. # _____

Spouse's (parent's) Employer _____ Work Phone # _____ Cell Phone # _____

EMERGENCY INFORMATION **(person other than parent listed above for minor)** Name _____ Relationship _____ Phone Number _____

Address _____ City _____ State _____ ZIP _____

How did you hear about our office? _____

DENTAL INSURANCE INFORMATION (Primary Carrier)	If you have secondary insurance coverage, complete this section
Insurance Co	Insurance Co
Policy Holder Name	Policy Holder Name
Employer	Employer
Insurance Co Address	Insurance Co Address
Phone # DOB	Phone # DOB
SS #	SS #
ID # Group #	ID # Group #

FINANCIAL POLICY

Thank you for choosing our office as your dental healthcare 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 service is provided. Our office accepts cash, personal 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 event the account is not paid in accordance with the financial arrangements made by discharge, or within 30 (thirty) days of discharge, I (we) will pay the processing fees and collection costs including reasonable attorney fees and court costs if this account is placed in the hands of a collection agency or attorney.**

Do You Have Insurance?

- As a courtesy to you, we will help you process all 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 central 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 that contract.
- Our practice is committed to providing the best treatment for our patients and we change what is usual and customary for our 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, check, 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 received 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 paid. Our office will not, however, enter into a dispute with your insurance company over any claim.

We 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.

Consent:

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 responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a finance, rebilling, collection charge and/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 any fees or charges that you may incur for an incoming call from us, and/or outgoing calls to us, to or from any such number without reimbursement from us.

_____ _____

Patient Signature *(Parent, if child)* Date