CONFIDENTIAL

Patient Registration Information

Date _____

Name _____ Patient # _____
First Mi Last

Welcome to our practice!

Thank you for selecting our dental healthcare team. Please fill out this form completely in ink. If you have any questions or concerns, please do not hesitate to ask for assistance-we will be happy to help!

Home address _____ City _____ State/Prov. _____ Zip/P.C. _____

Birthdate _____ Home Phone _____ Work Phone _____

E-Mail _____ Cell Phone _____

Do you prefer to receive calls at: ☐ Work ☐ Home ☐ Either

Are you: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Your or your parent/guardian's employer _____ Occupation _____

Business address _____ City _____ State/ Prov. _____ Zip/ P.C. _____

Spouse or parent/guardian's name _____ Employer _____ Work phone _____

If you are a student, name of school/college _____ City _____ State/ Prov. _____

Whom may we thank for referring you? _____

Person to contact in case of an emergency _____ Phone _____

Responsible Party

Name of person responsible for this account _____ Relationship _____

Address _____ Home Phone _____

City _____ State/ Prov. _____ Zip/ P.C. _____ SS #/SIN _____

Driver's license # _____ Birthdate _____ Financial institution _____

E-Mail _____ Cell Phone _____

Employer _____ Work phone _____

Is this person currently a patient in our office? ☐ Yes ☐ No

Insurance Information

Name of insured _____

Relationship to patient _____

Birthdate _____ SS #/SIN _____ Date employed _____

Employer _____ Work phone _____

Address of employer _____ City _____ State/ Prov. _____ Zip/ P.C. _____

Insurance company _____ Group # _____ Employer/cert. # _____

Ins. co. address _____ City _____ State/ Prov. _____ Zip/ P.C. _____

How much is your deductible? _____ How much have you used? _____ Max. annual benefit? _____

Please Continue... ☞

Additional Insurance

Do you have any additional insurance? ☐ Yes ☐ No If yes, complete the following:

Name of insured _____

Relationship to patient _____

Birthdate _____ SS #/SIN _____ Date employed _____

Employer _____ Work phone _____

Address of employer _____ City _____ State/ Prov. _____ Zip/ P.C. _____

Insurance company _____ Group # _____ Employer/cert. # _____

Ins. co. address _____ City _____ State/ Prov. _____ Zip/ P.C. _____

How much is your deductible? _____ How much have you used? _____ Max. annual benefit? _____

Authorization, Release, and Agreement to Pay For Services Rendered

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such Dental care to third party payors and/or other health practitioners.

I authorize and hereby request my insurance company to pay directly to the dentist (or the dental group) insurance benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actuci bill for services. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents.

X _____ _____

Signature of patient or parent/guardian if minor Date

Financial Arrangements

For your convenience, we offer the following methods of payment. Please check the option which you prefer. If you have any questions concerning financial arrangements or need special arrangements, please ask for assistance.

Payment in full at each appointment

_____ Cash

_____ Personal Check

_____ Credit Card _____Visa _____MasterCard

Card # _____ Expiration Date _____

Late Charges

If I do not pay the entire new balance within 25 days of the monthly billing date, a late charge of 1.5% on the balance then unpaid and owed will be assessed each month (if allowed by law). I realize that failure to keep this account current may result in you bein unable to provide additional dental services except for dental emergencies or where there is prepayment for additional services. I the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attemptin to collect on this amount or any future outstanding account balances.

Thank you for filling out this form completely. The information you have provided will help us serve your dental healthcare needs more effectively and efficiently. If you have any questions at any time, please ask us. We are always happy to help.