PATIENT REGISTRATION

TODAY'S DATE:_____

Single ☐
Widow ☐
Married ☐
Divorced ☐

Name _____ Date of Birth _____
Spouse's name _____ Date of Birth _____
If a child, parent's name _____
Address _____ City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____ Work Phone _____

Whom may we thank for referring you? _____

Employer _____
Business address _____
Present position _____
In case of emergency, who should be notified: _____ Phone _____
Person responsible for this account _____
Social Security # _____ Driver's license # _____

Email Address:_____

If you would like to pay with Credit Card:
Credit Card Information ☐MasterCard ☐Visa ☐Amex ☐Discover
Name on card _____
Card # _____ Exp Date _____/_____ CVV_____

Dental Insurance Information:
Insurance Carrier _____ Subscriber Name_____ DOB_____
ID or SSN # _____ Group # _____
Insurance company address _____
City _____ State _____ Zip _____

Release of Information:
☐ I authorize the release of information including the diagnosis, records; examination rendered to me, claims and payment information. This information may be released to:

☐ Spouse:_____
☐ Child(ren):_____
☐ Parent(s):_____
☐ Other:_____

☐ Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

Signed: _____ Date:_____

Additional Information:
May we call your work? ☐Yes ☐No
May we call your home? ☐Yes ☐No
May we call your cell? ☐Yes ☐No
May we leave a message on your answering machine to:
Remind you of appointments? ☐Yes ☐No
Ask you to call the office back? ☐Yes ☐No

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied. I will also be responsible for any and all fees associated with collecting any unpaid balance.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____

Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____

Signature of guarantor of payment/responsible party