

PATIENT REGISTRATION FORM (Must be filled in completely)

Patient's First Name		MI	Last Name		Birthdate		Sex	Marital Status
Home Address		Apt. Number		City	State	Zip	Home Phone	
Social Security Number			Employer			Cellular Phone		
Employer's Address				City	State	Zip	Work Phone	
Person Financially Responsible (if different)				Social Security Number		Date of Birth	Relationship to Patient	
Home Address (if different)		Apt. Number		City	State	Zip	Home Phone	
Employer's & Address (if different)				City	State	Zip	Work Phone	
Primary Dental Insurance	Policyholder		Date of Birth	Employer		Insurance ID Number		Relationship to Patient
Secondary Dental Insurance	Policyholder		Date of Birth	Employer		Insurance ID Number		Relationship to Patient
Primary Medical Insurance	Policyholder		Date of Birth	Employer		Insurance ID Number		Relationship to Patient
Secondary Medical Insurance	Policyholder		Date of Birth	Employer		Insurance ID Number		Relationship to Patient
Referred to this office by			Person to contact in case of emergency:				Telephone	

FINANCIAL POLICY – Please note the following:

All services must be paid for at the time of service. Financing is available, please ask for contract.

We will assist in the filing of your claim for insurance benefits but the responsibility of obtaining these benefits is yours.

Your appointment time was specifically reserved for you. No charges will be made for cancelled appointments provided 24 hours notice is given. Repeated instances of broken appointments without advance notice WILL result in additional charges depending upon the length of appointment missed.

There will be an additional service charge of \$25.00 for any returned checks.

There will be a finance charge of 1.5% per month (18% annually) on any unpaid balance over thirty (30) days.

All costs relating to the collection of past due accounts, INCLUDING REASONABLE ATTORNEY'S FEES, will be the responsibility of the patient, guardian or guarantor.

There is no charge for post-operative care following surgical treatment.

I have read, understood and freely agree to the terms and conditions set forth herein. Signing of this form constitutes consent to the imposition of all fees as outlined in this agreement. If you would like a copy of this agreement for your records, please ask the receptionist.

I certify that I have filled in this form to the best of my knowledge,

Patient or Financially Responsible Party

Date