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PATIENT REGISTRATION
PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

Patient's Name ______________________________ Date ______________
Last First Middle Preferred

Patient's Birthdate ___/___/___ Social Security Number ______-______-______

SINGLE___ MARRIED ___SEPARATED___DIVORCED___WIDOWED___

Home Address____
Street City State Zip

Home Telephone ______________ Work Telephone ______________ Cell Phone ____________

Preferred contact method(s) (please circle): Home / Cell / Work/Email E-mail Address: ______________

Patient's Occupation ______________ Patient's Employer______________________

Business Address ____

Who may we thank for recommending you to our practice? ______________________

Spouse or Parent's Name (if patient is a minor) ______________________________
Last Middle First Preferred

Spouse or Parent's Birthdate: ____/____/____ Spouse or Parents Contact Number(s)_ ______________

Spouse or Parent's Occupation ____________________ Employer ____________________

In case of an Emergency, please contact ______________________________

Home Phone ______________ Cell Phone ______________ Work Phone ______________

Who is responsible for this account? ______________________________

DENTAL INSURANCE

PRIMARY COVERAGE
Employee Name ______________________
Employee Date of Birth ______________________
Employer Insurance Company ______________
Policy/ Member ID No. ______________________
Group No. ______________________
Ins. Company Phone No. ______________________

SECONDARY COVERAGE
Employee Name ______________________
Employee Date of Birth ______________________
Employer Insurance Company______________
Policy/Member ID No.______________________
Group. No. ______________________
Ins. Company Phone No. ______________________

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Office Guidelines

Dental Insurance: Please note the following:

- Dental insurance is a contract between your Employer and the Insurance Company to assist you in meeting dental financial obligations. Your employer chooses the plan and the benefit level; it is not based upon treatment needed.
- Dental insurance is an aid and is NOT designed to cover all treatment costs.
- Most plans are written to cover only minimal care; please be aware that some, or perhaps all, of the services provided by our office may not be covered by your dental insurance company.

Financial Arrangements: Financial arrangements will be made prior to treatment. We accept cash, check, Visa, American Express, MasterCard, and Discover for your convenience. In addition, we offer payment plan options through Care Credit as well as Compassionate Finance upon approval. Past Due balances of 30 days or more will be charged an additional 1.5% monthly (18% APR).
Broken Appointment Policy: Your appointment has been reserved specifically for you. If you are unable to keep this appointed time we ask for 48 hours' notice so that we may use this appointment for another patient. Consistent broken appointments, late arrival (requiring rescheduling), and appointments cancelled with less than 48 hours' notice may necessitate a broken appointment fee ($36 per hour for duration of appointment length) or our office being unable to reschedule you or continue with your treatment.
Notice of Privacy Practices: A copy of our Privacy Practices is included in your new patient forms. The practice reserves the right to change the terms of its Notice of Privacy Practices and to make provisions effective for all protected health information that it maintains. By signing below; you acknowledge that you obtained this practice's current Notice of Privacy Practices and may request a copy at any time.

The information I have provided is complete and accurate to the best of my knowledge. I consent to whatever procedures are deemed necessary to diagnose my oral condition. I agree to be responsible for payment of all services rendered. I authorize a credit check should I ask for a credit. I acknowledge that I have read and understand the Office Guidelines.

Patient's Signature: ______________________________ Today's Date: ________________
Relationship to patient (if signed by a personal representative of patient)