

Patient Registration and Financial Agreement

Today's Date: _____

Patient Name: _____

Address: _____

Male ___ Female ___

Date of Birth: _____

Social Security #: _____

Parents names (if child): _____

Name of School/College (if full time student): _____

Home #: _____

Work #: _____

Cell #: _____

E-Mail Address: _____

Referred By: _____

Marital Status: _____

Occupation: _____

Other family members in this practice: _____

Person to contact outside of immediate family/household in case of an emergency:

Name: _____

Phone#: _____

Do you have Dental Insurance?

Yes ___ No ___

Insured's name: _____

Employed by: _____

Insured's Date of Birth: _____

Insured's SS#: _____

Dental Insurance Company: _____

Member ID: _____

Group #: _____

Do you have Secondary Insurance?

Yes ___ No ___

Insured's Name: _____

Employed By: _____

Date of Birth: _____

Social Security #: _____

Dental Ins. Co: _____

Member ID: _____

Group #: _____

Method of Payment:

Please select one of the following:

Payment in full at each appt. ___

Ins. co-payment in full at each appointment ___

Authorization

I hereby authorize payment directly to the Dental Office of the group benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment, and I understand that my dental insurance carrier may pay less or nothing for the actual bill for services. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information listed is correct to the best of my knowledge. I understand that I am responsible for all fees incurred for the above treatment and agree to pay according to the option I have chosen. Most insurance plans are payment assistance plans. They are not designed to cover the entire cost of treatment. This office is happy to submit claims to your insurance company on your behalf. **Any account balance over 45 days will incur a 1.5% finance charge. Additional charges may occur if the account is handled by a collection agency.**

Signature of Responsible Party: _____

Adult Patient ___ Parent ___ Spouse ___ Guardian ___