

# PATIENT REGISTRATION

Mark B. Whaley, D.D.S.

Aesthetic & General Dentistry

Whom may we thank, for referring you to our practice? \_\_\_\_\_

## Patient Information

Patient Name: \_\_\_\_\_  
Last name , First name - Middle initial (Preferred Name)

Gender: M F Family Status: \_\_\_\_\_ Email Address: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ (Mobile): \_\_\_\_\_

Preferred appointment time:  Morning  Afternoon Preferred Day:  Mon  Tue  Wed  Thu  Fri

Address: \_\_\_\_\_  
Street Apartment #

\_\_\_\_\_  
City State Zip Code

## Responsible Party Information

(If other than patient)

The following is the:  patient's spouse  person responsible for payment

Name: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ (Mobile): \_\_\_\_\_

Address: \_\_\_\_\_  
Street Apartment #

\_\_\_\_\_  
City State Zip Code

## Employment Information

This information is for the:  patient  responsible party

Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_  
Street Address City State Zip Code Phone

## Insurance Information (Primary)

Name of Insured: \_\_\_\_\_ Is the insured a patient?  Yes  No

Last First MI

Insured's Birth Date: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Insured's Address: \_\_\_\_\_  
Street City State Zip Code

Patient's relationship to insured:  Self  Spouse  Child  Other \_\_\_\_\_

Insured's Employer Name: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip Code

Insurance Plan Name and Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Insurance Information (Secondary)

Name of Insured: \_\_\_\_\_ Is the insured a patient?  Yes  No  
Last First MI  
Insured's Birth Date: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_  
Insured's Address: \_\_\_\_\_  
Street City State Zip Code  
Patient's relationship to insured:  Self  Spouse  Child  Other \_\_\_\_\_  
Insured's Employer Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Street City State Zip Code  
Insurance Plan Name and Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Emergency Contact Information In case of emergency, please contact:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_

### 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 is rendered.

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

Patients who carry dental insurance understand that all dental services are charged directly to the patient and that he/she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms, 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 finance charge of 1½% per month (18% per annum) on the unpaid balance is charged on all accounts exceeding 30 days, unless previously written financial arrangements are satisfied.**

I understand that the estimated fee listed for dental treatment is only extended for a period of three months from the date of the patient examination.

In consideration for the professional services rendered, I agree to pay therefore the reasonable value of said services to **Mark B. Whaley, D.D.S.**, 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 permission to you or your assignee, to contact me by telephone at my home, work, or mobile phone number(s) submitted on this form, to discuss any matters related to this form.

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

Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Signature of Patient (responsible party, parent, or guardian)

To the best of my knowledge, all of the preceding answers and information submitted are true and correct. If there is a change in my general or health information, I will inform the dental office prior to my next appointment, without fail.

\_\_\_\_\_  
Signature of Patient (responsible party, parent, or guardian) Date: \_\_\_\_\_