

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 First Middle (Preferred Name)

Social Security # _____ Birth Date: _____

Gender: M / F Family Status: _____ Email Address: _____

Phone #: Home: _____ Work: _____ Mobil: _____

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

Address: _____
Street Apartment #
City State Zip Code

Responsible Party Information

- Self (All required information is listed above. Please proceed to the next section)
 Spouse (Please complete the remaining portion of this section below)
 Parent/Guardian (Please complete the remaining portion of this section below)
 Other (Please complete the remaining portion of this section below)

Name: _____

Social Security #: _____ Birth Date: _____

Phone #: Home: _____ Work: _____ Mobil: _____

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: _____ Last First MI Is the insured a patient? Yes No

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: _____

Consent for Services

For services to be rendered by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for all costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment is rendered.

For any "emergency dental service" or any service performed without previous financial arrangements, payment for the service(s) must be paid for at the time it is rendered.

Patients who carry dental insurance must understand that all dental services are charged directly to the patient and that he/she is personally responsible for the payment of any dental service rendered. 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 office does not render service 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.

Estimated fees listed for dental treatment is only extended for a period of three months from the date of the patient examination/diagnosis.

In consideration for 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. I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant permission to Mark B. Whaley, D.D.S., or his 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.

Signature of Patient (or Parent, Guardian, or Responsible Party)

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

Signature of Patient (or Responsible Party, Parent, or Guardian) Date: _____