BASS LAKE DENTAL REGISTRATION

PATIENT

			MALE FEMALE
LAST NAME	FIRST	MIDDLE	PLEASE CIRCLE ONE
ADDRESS	CITY	STATE	ZIP
		MINOR SINGLE MARRIED DIVORCED SEPARATED	
BIRTHDATE	PHONE	PLEASE CIRCLE ONE	
IN CASE OF EMERGENCY, NAME OF NEAREST RELATIVE NOT LIVING WITH YOU	HOME PHONE	WORK PHONE	RELATIONSHIP

PERSON RESPONSIBLE FOR ACCOUNT / SPOUSE

PERSON RESPONSIBLE FOR ACCOUNT			SPOUSE		
FIRST NAME	M	LAST	FIRST NAME	M	LAST
STREET			STREET		
CITY	STATE	ZIP	CITY	STATE	ZIP
HOME PHONE	WORK PHONE		HOME PHONE	WORK PHONE	
DATE OF BIRTH	SOCIAL SECURITY NUMBER		DATE OF BIRTH	SOCIAL SECURITY NUMBER	
EMPLOYER AND ADDRESS			EMPLOYER AND ADDRESS		

INSURANCE RELEASE AND ASSIGNMENT

In order for us to process your insurance forms, please complete the section below. (Both sections if you have dual coverage.)

NAME OF INSURANCE COMPANY		GROUP #	NAME OF INSURANCE COMPANY		GROUP #
INSURANCE COMPANY ADDRESS			INSURANCE COMPANY ADDRESS		
If patient is not the policyholder, please complete the following:			If patient is not the policyholder, please complete the following:		
FIRST NAME	M	LAST	FIRST NAME	M	LAST
DATE OF BIRTH	SOCIAL SECURITY NUMBER		DATE OF BIRTH	SOCIAL SECURITY NUMBER	

AUTHORIZATION

Please read carefully and sign.

I hereby authorize release of information necessary to file a claim with my insurance company and authorize payment directly to Bass Lake Dental of the insurance benefits otherwise payable to me. I understand that my dental care insurance carrier or payor of my dental benefits may be less than the actual bill for services. I understand that I am financially responsible for payment in full of all accounts and for collection fees, court costs and reasonable attorney fees to collect unpaid accounts.

By signing this statement, I revoke any and all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by my dental or medical care payor.

I understand that a finance charge of 1.5% per month (18% per year) will be charged on any balance remaining 90 days after the charge is incurred, and that Bass Lake Dental may obtain a report of my credit history.

I hereby authorize this office to administer such medications and perform such diagnostic procedures as may be necessary for proper dental care.

IF CLIENT IS A MINOR: In addition to the foregoing, I authorize Bass Lake Dental to treat ____ and I understand that by requesting this treatment, I assume financial responsibility for treatment rendered. I certify that the information on this page is correct to the best of my knowledge.

SIGNATURE OF RESPONSIBLE PARTY:____ DATE:______________________

SIGNATURE OF RESPONSIBLE PARTY: ____ DATE:______________________