

PATIENT REGISTRATION

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

IF THIS APPOINTMENT IS FOR YOU START HERE

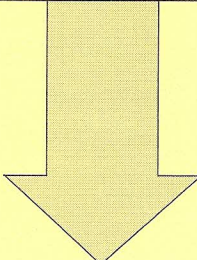
DATE				1
LAST NAME		FIRST	M.I.	
PREFERS TO BE CALLED BY				
ADDRESS				
CITY		STATE	ZIP	
HOME PHONE NO.			FAX	
CELL		EMAIL		
BIRTHDATE	AGE	MALE	FEMALE	
MARRIED	SINGLE	DIVORCED	WIDOWED	
SOCIAL SECURITY NO.				

DATE			
LAST NAME		FIRST	M.I.
ADDRESS			
CITY		STATE	ZIP
HOME PHONE NO.			
BIRTHDATE	AGE	MALE	FEMALE
SCHOOL		GRADE	
SOCIAL SECURITY NO.			

IF THIS APPOINTMENT IS FOR YOUR CHILD START HERE

IF YOUR CHILD'S LAST NAME AND/OR ADDRESS ARE NOT THE SAME AS YOURS, FILL IN THE TOP BOX ALSO

DENTAL INSURANCE		2
PRIMARY CARRIER		
INSURANCE COMPANY		
GROUP NO.		
EMPLOYER NAME		
INSURED'S NAME		
DATE OF BIRTH	RELATIONSHIP TO PATIENT	
INSURED'S I.D. NO.		
INSURED'S SOCIAL SECURITY NO.		
SECONDARY CARRIER		
INSURANCE COMPANY		
GROUP NO.		
EMPLOYER NAME		
INSURED'S NAME		
DATE OF BIRTH	RELATIONSHIP TO PATIENT	
INSURED'S I.D. NO.		
INSURED'S SOCIAL SECURITY NO.		



ACCOUNT INFORMATION		4
PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT		
NAME		
RELATIONSHIP TO PATIENT	SOCIAL SECURITY NO.	
ADDRESS		
CITY	STATE	ZIP
PHONE NO.		
YOU		
NAME		
OCCUPATION		
EMPLOYER'S NAME		
ADDRESS	CITY	
PHONE NO.	FAX NO.	
YOUR SPOUSE		
NAME		
OCCUPATION		
EMPLOYER'S NAME		
ADDRESS	CITY	
PHONE NO.	FAX NO.	

GETTING TO KNOW YOU		3
IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE?		
NAME:	RELATIONSHIP:	
YOU WERE REFERRED TO US BY		
YOUR FORMER ADDRESS		
CITY	STATE	ZIP
PERSON TO CONTACT FOR EMERGENCY		
PHONE NUMBER		
ADDRESS		
CITY	STATE	ZIP
CLOSEST RELATIVE NOT LIVING WITH YOU		
PHONE NUMBER		
ADDRESS		
CITY	STATE	ZIP

Financing Your Dental Care

1. **Pre-payment** by cash or check, with a 5% courtesy adjustment on treatment over \$700. Pre-payment saves us time and the expense of billing, which allows us to offer this valuable service.
2. **Pre-payment** by Visa, MasterCard, American Express or Discover, with a 2% courtesy adjustment on treatment over \$700.
3. **Payment Plan.** Payment arrangements may be made in advance with the financial administrator. They must be paid in full within 90 day. All arrangements must be documented and signed by the responsible party and the financial administrator.
4. **Extended Payment Plan.** A long –term payment plan is available through our financing partner Care Credit. Please ask for information and an application.

For those with insurance, we will file your insurance claim as a service to you and do our very best to maximize your dental benefits. We will accept assignment of benefits to lower your immediate out of pocket expenditures. We ask that you take care of your estimated portion of payment at the time of service.

All appointment are schedule in advance. As a courtesy to others, please be on time for your appointment. If you are unable to keep your appointment, **please notify our office at least 2 working days (48 hours) prior to the appointment or a No Show /Cancellation fee of \$50.00 may be charged.**

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) _____'s dental needs.
2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
4. I give consent to the doctor's or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.
5. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1/2% late charge (18% APR) may be added to my account. If required, I also understand a check of my credit history may be made.

Patient's Signature _____ Date _____ Witness _____

Parent/Responsible Party's Signature _____ Relationship to Patient _____