

PATIENT REGISTRATION

NAME _____ SS# _____ - _____ - _____
HOME ADDRESS _____
CITY _____ STATE _____ ZIP _____
HOME PHONE # () _____ - _____ DATE OF BIRTH _____ / _____ / _____
PLACE OF EMPLOYMENT _____
(NAME YOUR SCHOOL IF YOU ARE A STUDENT)
WORK PHONE # () _____ - _____ MOBILE # () _____ - _____
WORK ADDRESS _____
CITY _____ STATE _____ ZIP _____
MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOWED
IF MARRIED, SPOUSE'S NAME _____
WHICH DENTIST REFERRED YOU TO DR. HERPY? _____
WHICH ORTHODONTIST REFERRED YOU TO DR. HERPY? _____

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RESPONSIBLE PARTY/BILLING INFORMATION

IF PATIENT IS RESPONSIBLE FOR HIS/HER OWN BILL, PLEASE SKIP TO THE NEXT SECTION

RESPONSIBLE PARTY _____ SS# _____ - _____ - _____
HOME ADDRESS _____
CITY _____ STATE _____ ZIP _____
HOME PHONE # () _____ - _____
WORK PHONE # () _____ - _____ MOBILE # () _____ - _____

IF YOU HAVE DENTAL/MEDICAL INSURANCE, PLEASE FILL OUT BACK OF THIS FORM

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FINANCIAL POLICY

PAYMENT IS REQUIRED AT THE TIME OF SERVICE. WE REQUIRE A 24 HOUR CANCELLATION NOTICE FOR ALL SURGICAL PROCEDURES. FAILURE TO GIVE A 24 HOUR NOTICE WILL RESULT IN A \$100. FEE. PLEASE BE CURTEOUS IF YOU HAVE TO CANCEL YOUR APPOINTMENT.

MY PAYMENT WILL BE MADE IN THE FOLLOWING MANNER:

CHECK CASH VISA-M/C CARE CREDIT

I, THE UNDERSIGNED, ASSUME RESPONSIBILITY FOR MY ACCOUNT

(SIGNATURE)

(DATE)

INSURANCE INFORMATION

PRIMARY DENTAL INSURANCE

POLICYHOLDER _____ D.O.B. ____ / ____ / ____
SS# ____ - ____ - ____ ID # _____ GROUP# _____
RELATIONSHIP TO PATIENT _____
PLACE OF EMPLOYMENT _____
INSURANCE CARRIER _____
CLAIMS ADDRESS _____

PRIMARY MEDICAL INSURANCE

POLICYHOLDER _____ D.O.B. ____ / ____ / ____
SS# ____ - ____ - ____ ID # _____ GROUP# _____
RELATIONSHIP TO PATIENT _____
PLACE OF EMPLOYMENT _____
INSURANCE CARRIER _____
CLAIMS ADDRESS _____

SECONDARY INSURANCE DENTAL / MEDICAL

POLICYHOLDER _____ D.O.B. ____ / ____ / ____
SS# ____ - ____ - ____ ID # _____ GROUP# _____
INSURANCE CARRIER _____
CLAIMS ADDRESS _____

PLEASE PROVIDE US WITH YOUR INSURANCE CARD SO THAT WE MAY MAKE A PHOTOCOPY. AS A COURTESY, WE WILL SUBMIT YOUR INSURANCE CLAIMS FOR YOU. A DEPOSIT IS REQUIRED AT THE TIME OF SERVICE REGARDLESS OF YOUR INSURANCE COVERAGE. IF YOUR INSURANCE CARRIER HAS NOT PAID IN FULL WITHIN 60 DAYS, BILLING STATEMENTS WILL BE SENT TO YOU MONTHLY. IF YOU PLAN TO UTILIZE YOUR INSURANCE POLICY, PLEASE SIGN BELOW. PLEASE BE AWARE IF YOU ARE INSURED UNDER **MEDICARE**, MANY OF THE SERVICES PROVIDED IN THIS OFFICE ARE NOT COVERED BENEFITS AND YOU ARE RESPONSIBLE FOR PAYMENT.

I PLAN TO MAKE MY DEPOSIT IN THE FOLLOWING MANNER:

CASH CHECK VISA-M/C CARE CREDIT

I, THE UNDERSIGNED, ASSUME RESPONSIBILITY FOR MY ACCOUNT AND ASSIGN ALL MEDICAL AND/OR DENTAL BENEFITS DIRECTLY TO ALLEN K. HERPY, DDS, MS. I HEREBY AUTHORIZE DR. ALLEN HERPY TO RELEASE INFORMATION TO MY INSURANCE COMPANIES OR OTHER HEALTHCARE PROFESSIONALS.

(SIGNATURE)

(DATE)