Patient Registration Information Confidential

Date_____

Name_____Nickname_____
FIRST MI LAST

Welcome to our practice!

Thank you for selecting our dental healthcare team. Please fill out this form completely in ink. If you have any questions or concerns, please do not hesitate to ask for assistance.

Home address_____City_____State____Zip_____

Birthdate_____ Home Phone_____ Work Phone_____

Cell Phone_____ Email Address_____

Is it okay if we confirm your appointments by sending you a text message? ____yes _____no
Social Security Number _____

Are you:_____Minor ____Single___ Married_____Divorced _____ Widowed ____Separated

You or your parent's employer _____Occupation_____

Business address _____City_____ State____ Zip_____

Spouse or parent's name _____ Employer _____

If you are a student, name of school/college _____City_____State____

Whom may we thank for referring you? _____

Person to contact in case of an emergency _____ Phone_____

RESPONSIBLE PARTY:

Is this person currently a patient in our office? _____ Yes _____ No

Name of person responsible for this account_____

Relationship _____ Birthdate _____ Address _____

City _____ State _____ Zip Code _____

Home phone _____ Cell Phone_____

Social security # _____ Driver's license # _____

Employer _____ Work Phone _____

Please continue on other side

If You Have Insurance:

As a courtesy to our patients, we will gladly submit your claims for you. If you have Secondary Insurance, we will submit your claim one time per date of service. Please provide your insurance card, or cards to our office to be photocopied and placed in your chart. It is the patient's responsibility to pay their estimated portion when services are rendered.

Financial Arrangements:

For your convenience, we offer the following methods of payment. Please check the option which you prefer. If you have questions concerning financial arrangements, please ask for assistance.

Payment in full at each appointment

_____ Cash
_____ Personal Check
_____ Credit Card _____Visa _____MasterCard_____Discover _____Amex
Card # _____ Exp. Date _____
_____ I'm interested in Care Credit Dental Financing

Late Charges

If I do not pay the entire balance within 25 days of the monthly billing date, a late charge of 1.5% then unpaid and owed will be assessed each month (if allowed by law). After the first bill, a $5.00 billing fee may be added to each additional bill. I realize that failure to keep this account current may result in you being unable to provide additional dental services except for dental emergencies or where there is prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs including a 33.3% collection agency fee, and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding balances.

AUTHORIZATION, RELEASE, AND AGREEMENT TO PAY FOR SERVICES RENDERED

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such Dental Care to third party payors and/or other health practitioners.

I authorize and hereby request my insurance company to pay directly to the dentist, benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents.

X_____ _____
Signature of patient or parent if minor **Date**