Chet Desai, DDS

www.chetdesaidds.com

(714) 774-8640

PATIENT REGISTRATION

Patient Information

Patient's Name _____ **SSN** _____ **Date of Birth** _____ **Male** □ **Female** □
How do you wish to be addressed _____ **Single** □ **Married** □ **Separated** □ **Widowed** □ **Minor** □
Address _____ **City** _____ **State** _____ **Zip** _____
Home Phone _____ **Office Phone** _____ **Cell Phone** _____
Email _____ **Who may we thank for referring you?** _____
Someone to notify in case of emergency _____ **Phone** _____
Other family members in this practice _____

Account Information

Responsible Party's Name _____ **Date of Birth** _____ **Male** □ **Female** □
SSN _____ **Driver's License #** _____ **State** _____
Address _____ **City** _____ **State** _____ **Zip** _____
Home Phone _____ **Office Phone** _____ **Cell Phone** _____

Primary Dental Insurance

Insured's Name _____ **Date of Birth** _____
Employed By _____ **Occupation** _____
Relationship to the patient: **Self** □ **Spouse** □ **Parent** □
Name of Insurance Co. _____ **Phone** _____
Address _____ **City** _____ **State** _____ **Zip** _____
Policy/Group # _____ **Insured's ID** _____ **Insured's Social Security #** _____

Secondary Dental Insurance

Insured's Name _____ **Date of Birth** _____
Employed By _____ **Occupation** _____
Relationship to the patient: **Self** □ **Spouse** □ **Parent** □
Name of Insurance Co. _____ **Phone** _____
Address _____ **City** _____ **State** _____ **Zip** _____
Policy/Group # _____ **Insured's ID** _____ **Insured's Social Security #** _____

_____ **I hereby authorize assignment of my insurance rights and benefits to Chet Desai, DDS for services rendered.**
(Initials) **I understand I am solely responsible for any balance not paid by my insurance company.**

(See Reverse Side)

Release

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.
I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I authorize release of any information concerning my (or my child's) health care, advice and treatment to another dentist.

Terms

Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made. A one and one-half (1 ½) percent monthly finance charge is added to all amounts after 60 days from date of service. This represents an annual percentage rate of eighteen (18) percent. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collections agency fees, interest charges and any other expenses incurred in collecting your account. Additionally, a monthly late payment fee of upto $20 will apply to all delinquent accounts.

Cancellation Policy

We require 48 hours notice if you are unable to keep an appointment.
You will be billed for the time reserved if we are unable to fill your appointed time ($50 minimum charge). Thank you for your cooperation.

I have read and understand the Cancellation Policy.

I hereby assign all dental benefits directly to Chet Desai, DDS. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not paid by said insurance.

I attest to the accuracy of the information on this page.

Patient's or Guardian's Signature _____ Date _____