



Side 1
PATIENT
REGISTRATION

Patient Name (First, Middle, Last):

Prefers to be called:

Address (Street, City, State, Zip):

Home Phone: Cell: Email:

Birthdate: Age: Male Female Married Single Divorced Widowed

Social Security #: Employer's/School Name:

Occupation: Work Phone: OK to call work? Yes No

Is there another member of your family a patient at our office? Name:

Relationship: Who can we thank for referring you to us?:

Emergency Contact (other than at your home):

Relationship: Work# Home/Cell:

Person Financially Responsible for Account: Name (First, Middle, Last):

Relationship: Social Security #: Home/Cell:

Spouse Name: Spouse Occupation:

Spouse Employer: Work Phone: OK to call work? Yes No

If you have Dental Insurance, please continue:

Primary Insurance: Secondary Insurance:

Address: Address:

Phone: Phone:

Group/Program #: Group/Program #:

Subscriber Name: Subscriber Name:

Subscriber Birthdate: Subscriber Birthdate:

SSN/ID Number: SSN/ID Number:

Relationship to Patient: Self Spouse Dependent Relationship to Patient: Self Spouse Dependent



APPOINTMENTS:

We value your time, so you can expect us to see you at the appointed time. In return, when you make an appointment with us please be on time since we have reserved this time just for you. Please make every effort not to change your scheduled appointment with less than 48 hours' advanced notification. Broken and missed appointments creates scheduling problems for other patients. We value your time, please value ours.

FINANCIAL POLICY:

Because we care about your dental health, we offer choices for paying for your dental care. We accept the following forms of payment: Cash, Checks, Visa or Mastercard, and Third Party Financing (if approved).

We can help with discounts:

7% discount if paid by cash or check at time of scheduling. **5% discount** if paid by credit card at time of scheduling.

Insurance Policy - All insurance co-pays and deductibles must be paid at or before the time of service. We will submit all pertinent information electronically to your insurance company and help you to maximize your dental benefits while receiving your individualized dental care. In the event we do not receive payment from your insurance company within 60 days the balance will be required to be paid by you.

One Less Bill - We would like to retain your credit card on our secure portal for any charges less than \$100.00 to be automatically processed. You will receive an itemized receipt with explanation of the charges and amounts due. This means one less bill coming to your home.

Card Number: _____ Expiration: _____ Signature _____

_____ (read and initial) I have read and understand the financial options available to me, the account holder.

Account Holder Signature: _____ Date: _____

Members of my family this authorization applies to: _____

ACKNOWLEDGEMENTS (please initial):

- _____ I acknowledge that I have received a copy of the HIPAA Policy.
- _____ I authorize my insurance company to pay all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.
- _____ I authorize the dentist to release all information necessary to secure the payment of benefits.
- _____ I understand that I am financially responsible for all charges whether or not paid by insurance.
- _____ I have read and acknowledge the above Financial Policy.
- _____ I authorize my credit card to be on file for any outstanding balance.
- _____ I grant permission to reproduce the photographs/videos taken of me, for the purpose of publication, promotion, illustration, advertising, in any manner or in any medium.

CONSENT FOR TREATMENT (please initial):

- _____ I authorize the doctor or designated staff to take x-rays, study models, photographs and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my dental needs.
- _____ Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
- _____ 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.
- _____ I consent to the making of videotapes, photographs and x-rays before, during and after treatment, and to the use of the same by the doctor in scientific papers or demonstrations.
- _____ 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 options.
- _____ I certify that I have read or had read to me the contents of this form and do realize the risks and limitations involved.

SIGNATURE: _____ **DATE:** _____

PARENT/RESPONSIBLE PARTY'S SIGNATURE: _____

RELATIONSHIP TO PATIENT: _____