

PATIENT REGISTRATION

Name _____ Birthdate _____ Home Phone _____

Address _____ City _____ Zip _____

Social Security # _____

Check One Minor Single Married Divorced Widowed Separated

Patient or Parent's Employer _____ Work Phone _____

Spouse or Parent's Name _____

RESPONSIBLE PARTY

Name _____ Relationship to Patient _____

Address _____ Home Phone _____

Drivers License# _____ Birthdate _____

Employer _____ Work Phone _____

Office Payment Policy

The best doctor-patient relationships are maintained when there is complete understanding of the treatment rendered and the fee. Please feel free to discuss the fee prior to treatment. As a courtesy we will submit insurance, but we can not accept the responsibility for collecting insurance payments or for negotiating a disputed claim. Insurance is a contract between the patient and the insurance carrier. Even though you are covered by dental insurance, there will be a copay due on the day of your visit. Since it is not possible to predict the exact amount of the insurance payment, you can expect either an overpayment refund or a bill for the uncovered portion of the fee after the insurance payment is received by our office.

For your convenience we offer the following methods of payment: Please check one

Cash Visa - MasterCard - Discover Personal Check

DENTAL INSURANCE (If you have a secondary dental insurance, please inform the front desk.)

INSURANCE INFORMATION

Name of Insured _____ Relationship to Patient _____

Birth Date _____ Social Security # _____

Name of Employer _____ Work Phone _____

Insurance Company _____ Group # _____

Insurance Company Address _____ Telephone # _____

I authorize release of any information relating to this claim. I understand that my dental insurance may pay less than the actual bill for services. I agree to be responsible for the payment of all services rendered on my behalf or my dependents. I authorize and request my dental insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me.

Signature of Patient or Parent

Our office does not transmit claims electronically, so we are not required to distribute and obtain an Acknowledgement Notice of our privacy practices in writing. However, we do take our patient's health information seriously, and we will make every effort to protect privacy. It is our policy that we only disclose patient health information about treatment, payment, and healthcare operations. Any other disclosure of health information would require a written authorization.

Signature of Patient or Parent