Patient Registration

(Please Print)

Patient_____
Last Name First Name Middle Initial Preferred Name

Address_____ City_____State_____Zip_____

Phone: Home (__ ___)_____-___ _____ Work (__ ___) _ _ ___ -_____ _ ___ Cell (__ ___)_____-_____ _____

Sex: _____Male _____Female Age_____ Birth Date_____ SSN _____

Marital Status: ____Single ____Married ____Divorced ____Separated ____Widowed

Email address: _____ (optional)

Patient Employed by _____ Occupation_____

Do you have dental insurance? __ Yes, __ No If Yes: *Policy holder's* name (if different than above) _____

Policy holder's address _____*City*_____*State*_____*Zip* _____

Phone: Home _____ *Work* _____ *Cell* _____

*Social Security #*_____ *Member I.D. (if different than SSN)*_____ *DOB*_____

Employed by _____ *Occupation* _____

Dental Insurance Company_____ Group #_____

Who is responsible for this account?_____ Relationship to Patient_____

Preferred Pharmacy _____Location_____
(i.e. city, street name, intersection)

In case of emergency, who should be notified?_____ Phone_____

Relationship to Patient _____Whom may we thank for referring you? _____

When was your last cleaning by a hygienist or dentist? _____
(Number of months, years, or date)

Our mission…

To provide the highest quality dental care to our patients based upon a dedication to professionalism, trust and a commitment to building lasting relationships.

Authorizations and Disclosures

Please Initial the Following:

_____**Notice of Privacy Practices (HIPAA)**: I am aware of my rights to privacy of personal health information under the Privacy Rule of Health Insurance Portability and Accountability Act of 1996 (HIPAA) and that Notice of Privacy Practices were made available to me in writing upon request.

_____ **Assignment of Insurance & 3rd Party Benefits**: I hereby authorize and request my insurance company to pay directly to the dental office all benefits due to me under this claim.

____ **Financial agreement**: I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that parent/guardians are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges not covered by insurance. I realize that failure to keep this account current may result in this office being unable to provide additional services. In addition to the principle amount owed, I also agree to pay for all additional associated costs if my account is turned over to a collection agency or attorney in an effect to collect any outstanding balance.
Any payment amount due today is an estimate based upon my insurance coverage deductable and co-pay based on proposed treatment. However, if the procedure varies from what was scheduled or benefits differ from verified, I may incur additional charges.

_____ **Scheduling agreement**: Our practice is dedicated to your quality care and exceptional service. We respect the importance of your time and work very hard to schedule appointments that accommodate the busy scheduling needs of all of our patients. In return, we ask that patients make every effort not to change reserved dental appointments. Broken and missed appointments create scheduling problems for other patients as well as the practice. If you find you must change your appointment, we require a minimum of 24 hour notice so that we may accommodate another patient. A charge of $25.00 may be applied for broken and missed appointments without advanced notification. Thank you for your cooperation in this matter.
I have read and understand the *Authorizations and Disclosures*:

_____

Please Sign Here (state relationship to patient if not self) **Date**

See Back ------→