PATIENT REGISTRATION

Date _____

Patient's Name _____ Address _____

City _____ State _____ Zip Code _____ Date of Birth _____

If Child, Parent's Name _____ Home Phone _____ Business Phone _____

Cell Phone _____ Email Address _____

Place of Employment _____ Social Security # _____

Single ____ Married ____ Name of Spouse _____ Spouse Employed By _____

Spouse's Cell Phone _____ Spouse's Business Phone _____

Emergency Contact _____ Relation to Patient: _____ Phone # _____

Referred to Office By _____ Driver's License# _____

INSURANCE INFORMATION

Name of Insured: _____ Is insured a patient? Yes / No

Insured's Birth Date: _____ SS # _____ Group #: _____

Insured's Address _____

Insured's Employer Name: _____ Phone #: _____

Address: _____

Patient's Relationship to Insured: Self / Spouse / Child / Other _____

Insurance Plan Name / Address / Phone #: _____

_____

CONSENT FOR SERVICES

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is directly responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay the value of services to the Doctor at the time services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term of condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____

Signature of patient, parent, or guardian

Revised 1-2014