NEW PATIENT REGISTRAION

PATIENT INFORMATION (CONFIDENTIAL)		
Name:	Date	
Date of Birth:	SSN:	E-mail:
Cell Phone:	Work Phone:	Home Phone:
Current Address:		
City:	State:	ZIP Code
Circle appropriate: Minor Single Married Divorced Widowed Separated		
Spouse or Parent/Guardian's Name:		
Whom may we thank for referring you?		
Person to contact in case of emergency:		Phone:

RESPONSIBLE PARTY		
Name of person responsible for this account:		Relationship to patient:
Address:		
Birthdate	SSN:	Home phone:
Is the responsible party a patient in our office?		

INSURANCE INFORMATION		
Name of insured:		Relationship to patient:
Birthdate:	SSN:	Date employed
Employer:		Work phone:
Insurance company:		
Insurance Co. Address:		
City:	State:	ZIP Code
Phone:	Group #:	Policy/ID #:

FINANCIAL POLICY

Thank you for choosing us as your oral care and treatment providers. We are committed to your treatment being a success. The following is a statement of our financial policy, which we require that you read and sign prior to any treatment:

Methods of Payment: Payment is expected at the time services are rendered for all patients unless another formal financial agreement has been made in advance with our office. We accept cash, personal checks, Visa, Master Card, American Express, Discover, and Debit cards for this purpose.

Regarding Insurance: Your dental plan is designed to share in your dental care costs. It may not cover the total cost of your bill. We do ask for payment in advance, and will help you file the necessary paperwork and documentation to get the maximum benefit reimbursement from your insurance provider. We request that your insurance company send reimbursement checks directly to you.

In order for us to file claims on your behalf, you must supply us with all necessary insurance information. Please refer to your insurance manual for specific coverage.

Commitment to Appointment Policy: 48 hours' notice is required for canceled appointments. Missed appointments and canceled appointments with less than 48 hours' notice will be assessed a $50.00 fee, payable immediately. We understand that conflicts occur, but the more notice given, the better chance we have to appoint another patient in need of dental care. We ask that you respect our schedule as we do yours by seeing our patients in a timely manner.

I authorize and request my insurance company to pay directly to the dentist or dental group, insurance benefits otherwise payable to me. I accept financial responsibility for any remaining charges not covered by insurance. I understand and agree to this financial policy.

Signature of patient or responsible party   Date

Office Signature   Date