PATIENT REGISTRATION

Home Phone _____ Work Phone _____

PATIENT INFORMATION

Patient Name _____
(Last Name) (First) (Middle) (Preferred Name)

Street Address _____ City _____ State _____ Zip _____

Sex ☐M ☐F Age _____ Birthdate _____ Social Security Number _____

Place of Employment _____ Occupation _____

Business Address _____ City _____ Zip _____

Dental Insurance Co. _____ Group # _____ Coverage: ☐ Self ☐ Spouse ☐ Family

If Full-Time Student . . . name of school _____ Grade _____

Has any member of your family ever been treated in this office? ☐ Yes ☐ No Who? _____

Whom may we thank for referring you to our office? _____

FAMILY INFORMATION (Adults, please complete spouse . . . Minors, please complete Mother & Father)

Spouse's Name _____ Birthdate _____ Social Security Number _____

Address (if different from patient) _____

Place of Employment _____ Work Phone _____

Dental Insurance Co. _____ Group # _____ Coverage: ☐ Self ☐ Spouse ☐ Family

Father's Name _____ Birthdate _____ Social Security Number _____

Address (if different from patient) _____

Place of Employment _____ Work Phone _____

Dental Insurance Co. _____ Group # _____ Coverage: ☐ Self ☐ Spouse ☐ Family

Mother's Name _____ Birthdate _____ Social Security Number _____

Address (if different from patient) _____

Place of Employment _____ Work Phone _____

Dental Insurance Co. _____ Group # _____ Coverage: ☐ Self ☐ Spouse ☐ Family

IN AN EMERGENCY, if we are unable to contact any of the above parties, whom should we notify . . .

Name _____ ☐ Relative ☐ Friend ☐ Other

Address _____

Home Phone _____ Work Phone _____

PERSON RESPONSIBLE FOR ACCOUNT ☐ Patient ☐ Father / Mother ☐ Guardian ☐ Spouse

METHOD OF PAYMENT **Payment is appreciated at the time services are rendered.**

Does responsible party currently have an account with this office? ☐ Yes ☐ No

☐ Payment in full at each appointment (cash or personal check)

☐ I wish to discuss the Dental Office's Financial Policy

Please read carefully! The entire new balance must be paid within 25 days of the monthly billing date or **interest** will be applied to the last month's balance and added to the account for the current monthly billing period. The interest will be 1.5% per month (which is an APR of 18%) For balances under $200.00, a minimum $3.00 monthly service charge will be applied. In the event that I default on payment, **I shall pay** any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or or future outstanding accounts

AUTHORIZATION I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. I attest that the information on this page and the dental/medical histories are correct to the best of my knowledge. I grant to the dentist the right to release my dental/medical and other information about my dental treatment to third party payors and/or other health professionals. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that **I am responsible for all costs of dental treatment.**

Signature of Responsible Party _____ **Date** _____