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PATIENT REGISTRATION

Patient's Name _____

Street Address _____ Apt# _____

City _____ State _____ Zip _____

Phone _____ Cell/Pager _____

Name of Doctor you are seeing _____ E-mail _____

Patient Employed By _____ Phone _____ Ext _____

Business Address _____ Present Position _____

Birthdate _____ SS# _____ Marital Status M S W D

Name Of Spouse _____

Spouse Employed By _____

Business Address _____ Present Position _____

In Case Of An Emergency, Whom Should We Notify _____ Phone _____

Do You Have Dental Insurances Yes _____ No _____ Group# _____

Policy Holder _____ Policy# _____

Relationship to Policy Holder _____ Policy Holder Birthdate _____

Name Of Company _____ Phone _____

Purpose Of Visit _____

Whom May We Thank For Referring You _____

Consent Of Services Please Read Before Signing

Payment is expected in full at time of service. Any financial arrangements needing to be made must be made prior to scheduling a visit. Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he/she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms and submit them to your insurance company. However, this dental office cannot render services on the assumption that our charges will be paid by the insurance company. All emergency dental visits, or any dental services performed without previous financial arrangements, must be paid for in full at the time services are rendered

Our office follows all **HIPAA** guidelines to protect the privacy of your personal and healthcare information. By signing below you are acknowledging that we strive to follow these guidelines and that a copy of the privacy act is available to you if requested.

A broken appointment is a loss to everyone. We reserve the right to charge for appointments cancelled or broken without 24 hour notice.

Signature _____ Date _____