Side 1

PATIENT REGISTRATION

Patient Name (First, Middle, Last):____

Prefers to be called: ____

Address (Street, City, State, Zip): ____

Home Phone: _____________________ Cell:________________________ **Email:**_________________________________

Birthdate:_______________Age:________ ❑ Male ❑ Female ❑ Married ❑ Single ❑ Divorced ❑ Widowed

Social Security #: ________________________ Employer's/School Name: ____

Occupation:______________________________Work Phone:_____________________ OK to call work? ❑ Yes ❑ No

Is there another member of your family a patient at our office? Name:____

Relationship:______________________________Who can we thank for referring you to us?:________________________

Emergency Contact (other than at your home): ____

Relationship:____________________ Work#_________________________ Home/Cell: ___________________________

Person Financially Responsible for Account: Name (First, Middle, Last): ____

Relationship:_____________________ Social Security #:_____________________ Home/Cell: ______________________

Spouse Name:_________________________________ Spouse Occupation: ______________________________________

Spouse Employer:______________________________Work Phone:_________________ OK to call work? ❑ Yes ❑ No

If you have Dental Insurance, please continue:

Primary Insurance: _________________________________

Address: ____

____

Phone:____

Group/Program #: _________________________________

Subscriber Name: _________________________________

Subscriber Birthdate: ______________________________

SSN/ID Number: __________________________________

Relationship to Patient: ❑ Self ❑ Spouse ❑ Dependent

Secondary Insurance:______________________________

Address: ____

____

Phone:____

Group/Program #: _________________________________

Subscriber Name: _________________________________

Subscriber Birthdate: ______________________________

SSN/ID Number: __________________________________

Relationship to Patient: ❑ Self ❑ Spouse ❑ Dependent

PLEASE COMPLETE BOTH SIDES OF FORM

Side 2

OFFICE POLICIES

Insurance/Billing

As a courtesy, we accept assignment of benefits for primary and secondary insurance. It is your responsibility to provide our office with complete and accurate insurance or billing information at the time of service. We do our best to provide an estimate of your out of pocket cost but **our office cannot guarantee the amount that an insurance company will pay,** ultimately your insurance is a contract between you and the insurance company and we are not party to this contract. Disputes with insurance companies are the responsibility of the insured. We have no control over the terms of your contract, the method of reimbursement, or the determination of benefits. You agree to be responsible for payment of all services rendered. We can file a pre-determination for recommended treatment; however any pre-determination is only an estimate of insurance coverage. Our office will file a maximum of two times per treatment. **We request that you pay your estimated portion when services are rendered**. Any amount not covered by your insurance or any difference in the estimated portion is your responsibility. For your convenience we accept all major credit cards, check, cash and Care Credit. There will be a $30.00 fee for checks returned by the bank.

Responsible Party

Please be aware that the parent, guardian or patient who signs this consent form is legally responsible for payment regardless of whether or not they are the insurance holder. In the event of separation or divorce, the parent or guardian who signs this form is legally responsible for payment. *We cannot send statements to other parties.* Reimbursement must be made between divorced parents. We will not intervene.

Scheduling & Missed Appointments

Patients are seen by appointment only. Patients who are running late are asked to call the office as soon as possible and see if they will still be able to be seen. *Kindly notify us in advance if you are unable to keep an appointment, with a minimum of 48 hours notice*. We understand that there are circumstances that may prevent you from coming to your appointment. Giving us notice allows us to offer the appointment to other patients awaiting care. Habitually not showing for your appointment, or habitually cancelling your appointment will result in us not being able to schedule appointments for you unless they are on the same day you call for an appointment and may result in not being able to reserve peak appointment hours (very early /late appointments, or during school holidays).

Past Due Accounts

The office cannot carry balances longer than 60 days; regardless if insurance payment is still pending. If the insurance company does not pay the practice within 60 days, we will look to the responsible party for payment. If we later receive payment from the insurance, we will refund any overpayment. A service charge of 1.5% per month (18% per annum) on all unpaid balances will be assessed on all accounts exceeding sixty days from the date of service.

I have read and agree to the above Office Policies

Signature of responsible party   Date   Relationship to patient/patient name

PLEASE COMPLETE BOTH SIDES OF FORM