PATIENT REGISTRATION

First Name: _____Last Name: _____DOB: _____

Responsible Party: (if someone other than the patient)

First Name:_____ Last Name: _____ Middle Initial:____

Patient Information:

E-mail: _____

Street Address:_____

City _____, State _____, Zip: _____

Cell Phone: _____ Work Phone:_____ Home Phone_____

Insurance Information:

Name of Insured: _____Relationship to Insured:_____

Insurance Carrier _____ Group _____

Insurance ID or SSN _____

Medical History (circle all that apply)

Allergies:

asprin	amoxicillin	penicillin	codeine
latex	erythromycin	sulfa	local anestetics
no allergies	add your own _____		

Medical Conditions:

AIDS/HIV	anemia	arthritis	artificial joint
asthma	cancer	nursing baby	currently pregnant
diabetes	drug addiction	epilepsy or seizures	excessive bleeding
fainting/dizzy	heart disease	hepatitis	high blood pressure
kidney disease	mitral valve prolapse	pace maker	pain in jaw joint
rheumatic fever	sinus problems	stroke	thyroid disease
tuberculosis	ulcers	use of tobacco	no medical conditions

add your own _____

Treatments currently receiving :

chemotherapy	radiation	psychiatric
add your own_____	no treatment	

Current medications:_____

_____

Financial Agreement

We are committed to providing you with the highest quality lifetime dental care, so that you may attain optimum oral health. The following is a statement of our Financial Policy, which we require that you read, agree to, and sign prior to any treatment. We are pleased to discuss our professional fees with you at any time. Your clear understanding of the Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial Policy, or your responsibility upon arrival at your first appointment.

ADULT PATIENTS

Adult patients are responsible for full payment at time of service.

MINORS ACCOMPANIED BY AN ADULT

The adult accompanying a minor, his/her parents or guardians are responsible for full payment at time of service.

INSURANCE

We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company. Please understand that we will provide an insurance estimate to you, however, it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits will determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time. If you are paid by the insurance company instead of our practice, you then become responsible for the total account balance and payment would be expected immediately. We ask that you sign this form and/or any other necessary documents that may be required by your insurance company.

DEDUCTIBLE/CO-PAYMENT

We may ask that you pay the deductible and co-payment, which is the estimated amount, not covered by your insurance company, by cash, check, credit card or Patient Financing at the time we provide the service to you.

DELINQUENT PAYMENTS

It is our policy to charge a finance fee for outstanding patient balances. In addition, all payments returned due to non-sufficient funds will be subject to a fee.

MISSED APPOINTMENTS

Unless cancelled in advance, our policy is to charge a fee for missed appointments. Please help us service you better by keeping scheduled appointments.

REFUND POLICY

You may discontinue treatment and request a refund at any time for any amount that you paid for treatment that you did not receive. Please contact your office if you'd like to request a refund. By selecting Accept I confirm that I have read, understand and agree to the above terms and conditions. I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me. I understand that my dental care insurance carrier or payer of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payments of services not paid, in whole or in part by my dental care payer.

Signature _____date_____

PRIVACY POLICY

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I authorize the release of any information concerning my (or my child's) health care, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I authorize the release of any information concerning my (or my child's) health care, advice and treatment to another dentist.

I understand that I may withdraw or revoke my authorization at any time. I may revoke this authorization by notifying my practice in writing. I understand that by signing this Consent form, I am giving my consent to disclose and discuss my protected health information to carry out treatment, payment activities and health care operations. The undersigned hereby authorizes Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I have read, understand and agree to the above terms and conditions.

Signature_____date_____