PATIENT REGISTRATION

Today's Date:_____

Patient's Name: _____ Birth Date: _____
Social Security #: _____-_____-_____ Home Phone _____Cell Phone _____
If a child, parent's name _____ Spouse _____
Address_____ City: _____State: _____Zip:_____
Email Address _____
Would you be willing to get Appointment Notifications, Promotions & Specials and Newsletter on this email? Yes _____ No _____
Patient's Employer: _____ Phone: _____
Address_____ City: _____State: _____Zip:_____
Occupation: _____
Person responsible for this account: _____
Purpose of this appointment ❑ Complete Care ❑ Emergency Only ❑ Other _____
Referred to us by: _____

INSURANCE INFORMATION

Name of Policy Holder _____ Relationship to Patient _____
Name of Insurance _____
Date of Birth _____ SS# _____
Name of Employer_____
Employer Address _____ City _____ State_____ Zip_____
Group# _____ Policy ID#_____

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that the information will be used by the Dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the office.

Patients are expected to pay for professional services as they are rendered unless special and specific arrangements are made in advance. A finance charge is computed on a periodic rate of 1 ½% per month, which is an annual percentage rate of 18% on any previous balance not paid within 30 days ($1.00 minimum).

Failed appointments are very costly for everyone. Therefore, a minimum charge of $50.00 will be automatically billed to your account for appointments not cancelled at least 24 hours in advance.

Signature of patient (or parent if minor) _____