PATIENT REGISTRATION

Thank you for choosing our office.
In order to properly serve you we will need the following information. All information is strictly confidential.

PREFERRED CONTACT METHOD (SELECT ALL THAT APPLY) **PHONE:** ❑ WORK ❑ CELL ❑ HOME ❑ TEXT ❑ E-MAIL ❑ MORNING ❑ AFTERNOON

PATIENT INFORMATION

Date | Patient - Last Name | First Name | Initial | Preferred Name

Address | City | State | Zip

Sex ❑ M ❑ F | Age | Birth date | Single ❑ | Married ❑ | Widowed ❑ | Separated ❑ | Divorced ❑

Employed By | Cell Phone ( ) | Email

Social Security Number | Home Phone ( ) | Bus. Phone ( )

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT

Name and Relationship | Birth date

Address | City | State | Zip

Phone ( ) | Bus. Phone ( ) | Social Security Number

DENTAL INSURANCE INFORMATION 1ST COVERAGE

Employee Name | Birth date

Employer | Social Security Number

Insurance Company | Policy No. | Group No.

Address | City | State | Zip

Union Local or Group

DENTAL INSURANCE INFORMATION 2ND COVERAGE

Employee Name | Birth date

Employer | Social Security Number

Insurance Company | Policy No. | Group No.

Address | City | State | Zip

Union Local or Group

IN CASE OF EMERGENCY — PLEASE CONTACT

Name

Home Phone ( ) | Work Phone ( ) | Cell Phone ( )

AUTHORIZATION

** I authorize the health care provider to submit claims for payment of services to the health care service plan or insurance company named, on my behalf and in my name, and assign to such provider the group insurance benefits otherwise payable to me, but not to exceed the provider's actual charges for the covered services. I understand that I am financially responsible for any charges not covered by the group insurance benefits.

** I hereby authorize the Dental Office to administer such medications and perform such diagnostic, photographic, and therapeutic procedures as may be necessary for proper dental care. I consent to the use of appropriate medication and therapy as deemed necessary. I fully understand that using anaesthetic agents embodies a certain risk. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals by any method, including electronic transfer.

X______________________________ Date______________

Patient or Responsible Party Signature

METHOD OF PAYMENT

_____ Payment in full at each visit (cash, credit card, check)

_____ Care Credit or other third party services.

_____ Co-Pays for any contracted insurance plans.

I understand that I am responsible for all services provided by Zumbro View Dental X______________________________ Date______________

Patient or Responsible Party Signature

SERVICE CHARGE

Service charges accrue on any balances not paid in full within 30 days. I understand that a 1 1/2% finance charge (18% APR annual) may be added to my account. I further understand that I am responsible to pay any reasonable attorney's fees and costs of collection in the event of default.