Registration

Patients Name: ____Preferred Name:_______________

Mailing Address: ________________________________City:_________________Zip:___________

Home Phone: ______________ Cell:_________________ Work: ___________________________

Email: ____

Who can we thank for inviting you to our practice? _________________________________

What is the best way to communicate with you (circle all of interest): text / phone / email
Driver's License: ____-________________
State number

Sex: M F Age: ______ Birth Date: ____/____/______

SS#:___________________________

Single Married Widow Separated Divorced

Occupation: ______________________________

Employer: ____________________________ Employer Address: ____________________________

City: ________________________________ State: _________ Zip: _______________

If the person responsible for this patients account from the patient is a minor, the responsible party must fill out the section below. Otherwise, please skip to the section titled "Insurance Information".

Name of responsible party: ___________________________ Phone: ______________________

Mailing Address: ____

City: ___________________________________ State: ___________________ Zip: ____________

Insurance Information- *Please present insurance card*

Policy Holders Name: _________________________ Relationship to Patient:_________________

Employer: ____

DOB: _________________ Insurance Co: _________________________ Group#: _____________

Policy #: ___________________ ID #:_______________________ SS#:____________________

Address: _____________________________ City: ______________ State: _____ Zip: ____________

NEA Payor #: ________ Phone #: ___________________ Fax #: _________________________

We will file Secondary Insurance for our patients please provide secondary insurance information

Secondary Insurance Information

Policy Holders Name: ___________________________ Relationship to Patient______________________

Employer: _________________________________ DOB: ______________ Insurance Co: ____________________

Group#:___________________ Policy#:____________________ ID#:______________________

SS#:_____________________ NEA Payor #:_______________ Phone #:______________________

Address: ___________________________________ City: _____________ State: ________ Zip: __________

Goodall Family Dentistry is committed to providing the best treatment for our patients. As a healthcare provider our relationship is with you, not your insurance company. This statement has been prepared to prevent confusion and uncertainty regarding dental procedure and financial policies. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract. However, we may be a participating provider for the network. If we are a participating provider, we will make contractual adjustments as outlined in our participation agreement with the plan or network when payments are received. It is your responsibility to understand the provisions of your plan. We cannot guarantee payments of all claims submitted. If your insurance pays only a portion of your bill or rejects your claim, any explanation should be made to you in writing from your insurance company. Any financial portion not covered by insurance will be patient responsibility.

COPAYS AND DEDUCTIBLES MUST BE PAID AT THE TIME OF EACH VISIT.

Thank you for understanding the necessity of our financial policy. Please let us know if you have any questions or concerns regarding the above financial policy.

Goodall Family Dentistry gladly accepts Visa, MasterCard, Discover, Care Credit, Cash, and Checks.

Please Read and Sign The Following Agreement:

I hereby assign insurance benefits, otherwise payable to me, to pay directly to Goodall Family Dentistry. I understand I am responsible for charges and guaranteed payment not covered by my policy.

Patient/Guarantor's Name (please print): ____

Signature: ____________________________________ Date: _______________________