Patient Registration

Date_____

Name_____

Home phone number_____ Cell phone number_____

Address_____City_____

State___Zip_____ e-mail address_____

Male_____Female_____Birthdate_____Social Security Number_____

Patient Employed by_____Occupation_____

Business Address_____Phone_____

Who may we thank for referring you? _____

In case of emergency who should be notified _____Phone_____

Relation to Patient_____

Dental Insurance Information

Subscriber Name_____Relation to patient_____Phone_____

Address (if different from patient) _____Birthdate_____

City_____State_____Zip_____Social Security Number_____

Subscriber employed by_____Business Phone_____

Insurance Co_____Phone_____

Address_____Group/Contract/Subscriber Number_____

City_____State____Zip_____

Annual Maximum_____ Yearly Renewal Date_____
If new insurance, is there a waiting period for certain procedures?_____

(Please complete other side)

Treatment Information and Financial Statement

Before treatment can be rendered, adequate x-rays of the teeth and mouth must be taken. Please let us know if you've had any x-rays at a previous dentist so we may request them.

With your consent we use local anesthetic and other methods of pain control to make treatment more comfortable. We do not use general anesthetic. We do use nitrous oxide as necessary and with prior consent.

Payment of ALL initial and emergency visits is due when services are rendered. If you have dental insurance we will help you file for your reimbursement. At future appointments we will accept payment from your insurance company as determined by a pre-authorization.

Unless otherwise arranged, payment, or your portion of payment, is required on the day of treatment. We do accept VISA, Mastercard, American Express and Discover Card for convenience. Flexible payment plans are available, including interest free options through Care Credit and a discount for cash payment on qualifying amounts. If you have dental insurance you can help us by providing the following information about your insurance policy, so that we may anticipate your dental benefits accurately. We need the annual maximum benefit (amount your policy will pay yearly) and the date of annual renewal (date the unused benefits are lost and the annual maximum starts over). This is usually, but not always, January 1st. You can find this information in your policy explanations of benefits or get it from your employer or your insurance provider. Without this information we cannot help you avoid situations that may cost you money. Please provide us with this information as soon as possible, and advise us any time your policy changes.

Appointments are confirmed 48 hours in advance. We expect our patients to call if they are unable to come to their appointment because missed appointments keep other patients from receiving the treatment they need. Failure to notify us 48 hours in advance will result in a minimum charged of $35.00 to your account.

Patients who have not returned to our office or received a dental examination in over 18 months are considered inactive, and must be re-evaluated prior to receiving any dental services.

I consent to the taking of photographs and to the performing of dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anesthetic and nitrous oxide as indicated. I fully understand that using anesthetic agents embodies certain risks and that I can ask for a complete recital of any possible complications. I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to bruising, hematoma: cardiac stimulation; temporary or rarely, permanent numbness; or muscle soreness. I understand that occasionally needles break and may require surgical retrieval. I understand that I will be informed of any treatment changes as they occur.

Patient/Guardian Signature_____

I will be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by the agreed upon dates I understand that a 1 ½% finance charge (18% annually) will be added to any balance over 30 days. In the event of default, I promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of the debt. I understand that insurance coverage disputes are between the policy owner (me) and the insurance carrier, and that I am responsible for all debts.

Patient/Guardian Signature_____
Doctor's Signature_____