PATIENT REGISTRATION

Patient Information Today's Date_____
First Name: _____ Last Name: _____
Patient Is: □ Policy Holder □ Responsible Party □ Dependent
Address: _____City, State, Zip: _____
Home Phone: _____Work Phone: _____ Ext: _____ Cellular: _____
Sex ○ Male ○ Female Marital Status: ○Married ○Single ○Divorced ○Separated ○Widowed
Birthdate: _____Age: _____Soc. Sec: _____Drivers Lic: _____
E-mail: _____ □ I would like to receive correspondences via e-mail
Employment Status: ○Full Time ○Part Time ○Retired Student Status: ○Full time ○Part time
Employer: _____ Work Phone: _____

Emergency Contact (*not at same address*): _____Phone: _____
Referred by: _____

Responsible Party (*if someone other than the patient*) Relationship to patient: _____
First Name: _____ Last Name: _____
Address: _____ City, State, Zip: _____
Home Phone: _____ Work Phone: _____ Ext: _____Cellular: _____
Birth Date: _____Soc. Sec: _____Drivers Lic: _____

Primary Insurance Information
Ins. Company: _____
Address: _____
City, State, Zip: _____
Name of Insured: _____
Relationship to Patient: ○Self ○Spouse ○Parent ○Child ○Other
Insured SSN or ID#: _____ Group #: _____
Employer:_____Insured Birth Date:_____

Secondary Insurance Information
Ins. Company: _____
Address: _____
City, State, Zip: _____
Name of Insured: _____
Relationship to Patient: ○Self ○Spouse ○Parent ○Child ○Other
Insured SSN or ID#: _____ Group #: _____
Employer:_____Insured Birth Date:_____

Financial Agreement: *Please indicate your choice of payment below.*
○ Dental Insurance. Claims will be processed and then I will pay any difference.
○ Payment in full on the day of treatment. (2% discount over $100.00.)
○ Credit/Debit card payment: VISA, Mastercard, American Express and Discover Card accepted.
○ Open account. No interest will be charged if account is paid in full in 60 days. One and a half percent per month (18% annually) will be charged on outstanding accounts. Minimum finance charge per month will be $3.00.

In the event that full payment for charges incurred in my dental care is not made, I agree to pay all costs of collection, including 50% collection agency commission, reasonable attorney's fees, and interest at the rate of 18% per annum.

X Signature _____ Date_____