PATIENT REGISTRATION AND MEDICAL HISTORY

DATE:______________________

NAME: ____
Last First Middle

STREET ADDRESS: ____CITY______________________STATE________ZIP__________

DATE OF BIRTH: ____________________________ SOCIAL SECURITY #:______________________________________

HOME TELEPHONE #: _______________________CELL #:___________________________EMAIL:______________________________

SEX: M_______ F______ CHECK ONE: MARRIED_____ SINGLE_____ WIDOWED_____ DIVORCED______

EMPLOYED BY: ____OCCUPATION:____________________________________

WORK # _______________________WORK ADDRESS: ____

DENTAL CLINIC OR DENTIST WHO REFERRED YOU: _____________________________________ **PHONE #**_______________________

INCASE OF AN EMERGENCY WHO SHOULD BE NOTIFIED: ________________________________ PHONE #_______________________

FAMILY PHYSICIAN: ____PHONE #________________________

DENTAL INSURANCE INFORMATION

NAME OF INSURANCE COMPANY: ____

POLICY/ID#____ GROUP#____

POLICY HOLDER: SELF/ SPOUSE/ PARENT/ OTHER_____________ POLICY HOLDER NAME: ______________________________________

POLICY HOLDER'S DATE OF BIRTH: ___________________________ SOCIAL SECURITY #:_____________________________________

Insurance Policy

Our office at no time guarantees what or how the patient's dental insurance will or will not process a claim. Each and every claim is subject to review by the insurance company before the claim is processed. The dental insurance carrier never guarantees payment of any service. ***"Verification of benefits does not guarantee payment. Payment will only be made after claim is submitted."*** We can only assist the patient in estimating their portion of the cost of treatment based on the information we have gathered from the insurance company website, fax back, or representative. I, the undersigned, have insurance with _______________________.I understand that the office is not responsible for how a patient's dental insurance company handles the claims or for what benefits they pay on a claim. I am financially responsible for all charges whether or not paid by the insurance. I hereby authorize the office to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submission whether manual or electronic.

Patient's Signature: ____ Date: ________________________

Financial Agreement

I, acknowledge that payment is due at the time of treatment, unless other arrangements are made. I accept full financial responsibility for all charges.

Patient's Signature: ____ Date: ________________________

Broken Appointment Fee

Since our time with our patients is very precious to us and lost time is irretrievable, we must charge for broken appointments when we have not been notified at least 24 hours in advance. Our desire is never to find it necessary to make this charge. Please make every effort to notify us if you are unable to keep your appointment. Those fees vary from $40-$60 per appointment.

Patient's Signature: ____ Date: ________________________

Minor/Child Consent

I, being the parent of _____________________________________do hereby request and authorize the dental staff to perform necessary dental services for my child, including but not limited to x-rays and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when treatment is rendered. I also agree that parent/guardian is responsible for all fees and services rendered for treatment of a minor/child.

Patient's Signature: ____ Date: ________________________