REGISTRATION & CONSENT

Patient Name _____ Date of Birth _____/_____/_____
First M.I. Last

Address _____

City _____ State _____ Zip Code _____

Patient Social Security Number _____ Home Telephone (_____) _____

Patient Employed By _____ Work Telephone (_____) _____

If Patient is under 18:

Your Name _____ Date of Birth _____ Social Security# _____

Your Employer _____ Work Telephone (_____) _____

If patient has insurance coverage through another subscriber:

Subscriber Name _____ Date of Birth _____ Social Security#_____

Patient Relationship to Subscriber (check one) Spouse ____ Child ____ Other ____

Subscriber Employed By _____ Work Telephone (_____) _____

Dental Insurance Companies:

Name of Primary Carrier _____ Group # _____ ID# _____

Name of Secondary Carrier _____ Group# _____ ID# _____

Referred By _____

MEDICAL HISTORY

Are you (the patient) in good health? ___ yes ___ no

Are you (the patient) under a physician's care at this time? ___ yes ___ no If yes, please give reason(s) _____

_____

Are you (the patient) taking any kind of medication at this time? ___ yes ___ no If yes please list _____

_____

Please circle any illnesses you (the patient) may currently have or ever had:

Allergies	Tuberculosis	Anemia	Kidney/Liver	Diabetes
Rheumatic Fever	Heart Trouble	Asthma	Infectious Hepatitis	Epilepsy
Glaucoma	HIV/AIDS	Other: _____		

Have you (the patient) ever had trouble with prolong bleeding? ___ yes ___ no

Have you (the patient) ever had an unusual reaction to any drugs (like penicillin) or other products (like latex)? ___ yes ___ no

If yes, please list _____

Is there any information that should be known about your (the patients) health? ___ yes ___ no If yes, please list _____

_____

Is there any information that should be known about previous dental visits? ___ yes ___ no If yes, please list _____

_____

PRACTICE POLICIES

Thank you for selecting us for your dental care. To provide a long-term mutually satisfying relationship, we would like to explain our office policies regarding treatment, insurance, appointments, fees, financial responsibility, credit and billing. PLEASE read this carefully and ask questions about any concerns you may have BEFORE treatment is rendered. Submission to treatment implies consent to the terms of this agreement.

TREATMENT: I am dedicated to helping you improve your dental health as quickly as possible. Every effort will be made to make your appointment as comfortable and pleasant as possible. Please feel free to discuss your treatment with me at any time.

INSURANCE: We submit all insurance claims requesting assignment of benefits to be paid to us. Any balance not covered by your insurance carrier is still owed by the patient or responsible person. However, not all carriers will reimburse us directly. Typically those carriers are **United Concordia** and **Delta Dental** but even then there are exceptions. For those two carriers, typically payment will be due at the time of service unless other arrangements are made in advance. We will submit a claim on your behalf in which the subscriber will be reimbursed the coverage allowed by your plan. We also make no guarantee of any payment by any insurance carrier.

APPOINTMENTS: When we schedule your appointment, my time is reserved exclusively for you or your child. When patients fail to notify us of their inability to keep an appointment, another patient in need of dentistry is unable to receive treatment. We request that you give us at least 24 hours notice when an appointment cannot be kept. When a notice is not given, a fee of $50.00 per half hour will be charged.

FEES: I keep my fees within the 40 to 50th percentile of dental fees being charged in this area. Meaning, my fees are average or slightly below. For that, you get my undivided attention the entire length of any appointment. I use low radiation digital x-ray equipment, the best restorative materials available and only the highest quality prosthetic laborites. I know of no other office that can say that.

FINANCIAL RESPONSIBILITY: Persons 18 or older are financially responsibility for their own treatments regardless of insurance. If a parent is to be financially responsible for a person 18 or older, that parent would need to sign this form. For persons under 18, the parent that registers the child and signs this form will be financially responsible party regardless of who may provide insurance coverage.

CREDIT: When credit is extended, which occurs when payment is not rendered in full at the time of service regardless of insurance, we will require your social security number to be placed on file. The only way to avoid this is to pay in full at the time of service. First time appointments that are for emergencies, consultations or second opinions, payment must be made in full regardless of insurance.

BILLING:

1. A minimum fee of $5.00 will be applied to accounts with balances outstanding 60 days or longer regardless of outstanding insurance.
2. Returned checks will have a fee.
3. Credit reporting will have a fee.

I the undersigned acknowledge that I have read and understand these policies.

Patient/Parent & Financially responsible party signature _____

Print Name: _____ **Date:** _____