

Patient Registration Form (Please Print)

Date: _____

Child's Name: _____ Birth Date: _____

Home Address: _____

Home Phone #: _____

Father's Name: _____ Birth Date: _____

Employer: _____

Occupation: _____ SSN#: _____

Father's Home Phone: _____ Work: _____ Cell: _____

Mother's Name: _____ Birth Date: _____

Employer: _____

Occupation: _____ SSN#: _____

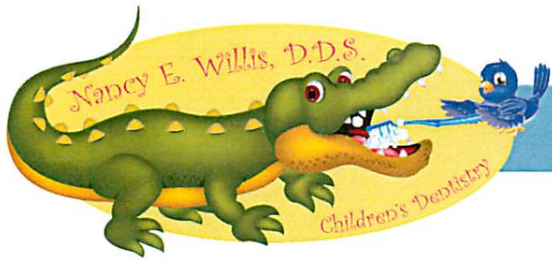
Mother's Home: _____ Work: _____ Cell: _____

Do you have dental insurance? YES NO

Carrier: _____ Subscriber: _____

Who is financially responsible for the account? _____

Emergency contact (other than parent): _____



Financial Guideline

All parent/guardians must complete information prior to their child being seen. Our office guidelines state that all patients are taken back for treatment solo from the age of three years old and on.

Patients with Insurance:

As a courtesy, our office will submit dental insurance claims to your insurance company. All insurance information must be presented and coverage verified prior to the appointment. Otherwise, we are not able to submit claims. All patient co-pays and deductibles are the subscriber's responsibility and are due at the TIME TREATMENT IS RENDERED.

Your insurance policy is a contract between you and your insurance company. We are not party to that contract. It is the subscribers responsibility to know what their insurance covers. Parents or guardians are responsible for FULL payment of treatment not covered by insurance.

Usual and Customary Rates:

Each insurance company determines their own usual and customary rates for each procedure. This is not necessarily equivalent to our fees. Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary in our area for the recommended treatment.

Transfer of Records:

When a request is made for records to be transferred to another dental office, we will be happy to send a treatment summary letter and radiographs. There will be a copying fee of \$10 for a panorex and \$5 for bitewings, occlusal or periapical films. These fees must be paid in full before radiographs can be released.

Missed Appointments:

Our office required 48 hours advance notice to cancel or reschedule an appointment. If 48 hours advance notice is not given, this is considered a broken appointment. There is a fee of \$50 per child, per broken appointment. Please help us serve you better by keeping scheduled appointments. Be aware that patients missing 2 scheduled appointments without advance notice, will be dismissed from the practice and advised in writing to seek care at another office.

Thank you for understanding our Financial Guidelines. Please let us know if you have any questions.

I have read, understand and agree to the Financial Guideline.

Signature: _____ Date: _____