NEW PATIENT REGISTRATION

Patient Name _____ Preferred Name _____

Birthdate_____ Social Security Number _____

Patient address_____

City_____ State_____ Zip Code _____

Home phone_____ Cell phone_____

Patient's place of employment _____ Work phone _____

I would like to receive correspondence via: ☐ Text ☐ Email _____ ☐ Both

Name, relationship, and phone number of person we may contact in case of emergency other than significant other

_____

Whom may we thank for referring you to our office? _____

PAYMENT ARRANGEMENTS

I HAVE NO DENTAL INSURANCE: I elect to pay with ☐ Cash ☐ Check ☐ Credit Card

I HAVE DENTAL INSURANCE: Primary insurance company _____

Whose name is insurance under/place of employment?_____

Group number _____ ID#_____ Date of birth of insured_____

Secondary insurance company name_____

Whose name is insurance under/place of employment?_____

Group number _____ ID#_____ Date of birth of insured_____

I understand that my dental insurance carrier may pay less than the actual bill for service, and that I am responsible for payment in full on my account. For extensive treatment, Care Credit is available and can be discussed prior to the start of treatment. I understand that an interest rate of 1.5% per month will be added to unpaid balances. If the account must be turned over to a third party for collection, the person listed as head of household will be responsible for all additional collection costs incurred.

Signature (if minor, parent or guardian signature)_____ Date _____