



PATIENT REGISTRATION

To help us meet your dental needs, please fill out this form completely in ink. If you have any questions, please ask someone at the front desk and we will be happy to help you. Thanks for being our patient!

PATIENT INFORMATION

Name _____
LAST FIRST MI

Parent / Guardian _____

Male Female Single Married Other

Birth date _____ SSN _____

Driver's License _____ State _____
(Photocopy required)

Address _____

City _____ State _____ Zip _____

H Phone _____ Cell _____

E-mail _____

Employer _____ Wk Phone _____

Emergency Contact _____

Emergency Phone _____

How did you hear about us? _____

INSURANCE INFORMATION

Name of Insured _____

Insured's SSN _____ DOB _____

Insurance company _____ Phone _____

Employer _____ Group _____

Insured's Relationship to Patient _____

School (full-time students) _____

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage with the above insurance company and assign directly to the office all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize this office to release all information necessary to secure the payment of benefits. I authorize the use for this signature on all insurance submissions.

 Responsible Party Signature

 Relationship to Patient

 Date

Office Policies

We have established the following office policies. Please place you initials by each to indicate that you have read them.

- _____ Payment and/or co-payment is required in full at the time of services are provided.
- _____ A \$12 infection control fee is charged for each visit. This fee covers the disposable items and the sterilization and disinfectant technology involved in your visits are required by law (OSHA)
- _____ At least 48 hours advance is required for all appointment changes or cancellations. Otherwise, a \$25 fee is charged for each appointment so affected.; an additional \$25 cancellation fee is charged for appointments with specialists.
- _____ If you have any questions about your insurance, please let us answer them before treatment begins. Otherwise, the assumption will be made that you are familiar with your dental plan coverage and limitations. *Please note that dental insurance is very different from medical insurance and that in most cases a co-payment is required.*
- _____ Please be advised that the co-payment requested for services rendered is *only an estimate* of what the insurance will not cover, as determined from the information provided by the insurance company. The information give to our office is not a guarantee of payment and the actual insurance benefit may differ from our estimates. *The account holder is responsible for all charges the insurance company does not pay within 45 days.*
- _____ Valid identification is required for all personal checks. Returned checks will be subject to the terms and conditions of the electronic check acceptance company used in this office, including any fees charged directly by that company.
- _____ Past due accounts (having a balance due for more than 60 days) will be charged 1.5% interest per month until accounts is reconciled. Delinquent accounts (having a balance due for more than 90 days) will be transferred to a collection agency or the Maryland State Clerk of Courts. Any and all charges incurred in the pursuit of the debt by any third party will be the full responsibility of the account holder.

I, the undersigned, certify that I have read, understand, and agree to abide by the above policies.

X _____
 Responsible Party Signature

 Date