PATIENT REGISTRATION

PATIENT NAME (PLEASE PRINT):	SEX:	DATE OF BIRTH:
STREET ADDRESS:	CITY:	STATE: ZIP:
RESPONSIBLE PARTY NAME (IF MINOR):	RELATIONSHIP:	
MOBILE PHONE NO:	HOME PHONE NO:	
E-MAIL ADDRESS:		
EMERGENCY CONTACT:	RELATIONSHIP:	PHONE NUMBER:
HOW DID YOU HEAR ABOUT OUR PRACTICE?		

INSURANCE INFORMATION

IF YOU WISH FOR US TO PROCESS INSURANCE CLAIMS ON YOUR BEHALF, COMPLETE THIS PORTION AND SIGN BELOW:

PRIMARY INSURANCE CARRIER:		SECONDARY INSURANCE CARRIER:	
EMPLOYER'S NAME:		EMPLOYER'S NAME:	
SUBSCRIBER NAME:	DOB:	SUBSCRIBER NAME:	DOB:
SUBSCRIBER POLICY NO:		SUBSCRIBER POLICY NO:	
PATIENTS RELATIONSHIP TO SUBSCRIBER:		PATIENTS RELATIONSHIP TO SUBSCRIBER:	
INSURANCE ADDRESS:		INSURANCE ADDRESS:	
GROUP PLAN NAME:	GROUP PLAN #:	GROUP PLAN NAME:	GROUP PLAN #:

I AUTHORIZE THE RELEASE OF ANY INFORMATION NECESSARY TO PROCESS INSURANCE CLAIMS. I ALSO AUTHORIZE INSURANCE PAYMENTS BE MADE DIRECTLY TO THE DENTAL OFFICE. I ACKNOWLEDGE AND AGREE THAT I AM RESPONSIBLE FOR PAYMENT OF ALL CHARGES NOT PAID BY MY INSURANCE CARRIER. I UNDERSTAND THAT PAYMENT IS EXPECTED WHEN SERVICES ARE RENDERED.

SIGNATURE: _____ DATE: _____

ELECTRONIC COMMUNICATION:

Accept _____ I agree to receive electronic communication from the practice. I agree to receive text messages, emails and voicemail.
Please note:

- When you opt in to receive SMS messages, we collect your phone number and your consent to send SMS messages ONLY
- Messaging and data rates may apply
- Message frequency may vary
- We use your information to send you the SMS messages you've opted in to receive and provide updates, promotions, or other relevant content based on your preferences
- We do not share your phone number or SMS opt-in information with third parties for marketing purposes
- We implement reasonable measures to protect your personal information from unauthorized access or disclosure
- You can opt out of receiving SMS messages at any time by replying with "STOP" to any message we send you
- If you have questions or concerns about our privacy practices, contact our office

Decline _____ I do not wish to receive any electronic communication. Please note: If you decide to opt-in, please notify our team.

MEDIA:

Accept _____ I authorize full permission to use images taken of myself/my child. I understand that I can revoke this release, in writing, at any time. We will use the following social media platforms:

- Facebook
- Instagram
- TikTok
- Website
- Google Business Listings/Reviews

Decline _____ I do not authorize the use of any images taken of myself/my child

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:
You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature Date

For Office Use Only

_____
We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ❑ Individual refused to sign
- ❑ Communications barriers prohibited obtaining the acknowledgement
- ❑ An emergency situation prevented us from obtaining acknowledgement
- ❑ Other (Please Specify)

OFFICE & FINANCIAL POLICIES

Welcome to our Practice. Our goal is to provide exceptional dental care for you and your family in a relaxed and pleasant environment. To provide you with a full understanding of our office and financial policies, kindly review and sign below. We appreciate the opportunity to serve you and thank you for choosing us to take care of your dental needs.

FINANCIAL POLICY: (please initial) _____

To provide the best service possible, payment, including deductibles and the estimated amount not covered by your insurance will be due at the time of service.

For your convenience, we accept cash, personal checks, Visa, Mastercard, Discover, American Express, and Care Credit. Third Party Financing is subject to credit approval and additional fees may apply.

Due to contractual obligations, we are required to charge fees based on the insurance company's determinations and third-party financing. No additional discounts can be applied.

A service fee of $35 will be applied to the account for handling any returned checks.

If your account becomes delinquent, it may be forwarded to an outside collection agency. If this happens, you will be responsible for all costs of collection, including but not limited to, interest, rebilling fees, court fees, attorney fees, and collection agency costs.

INSURANCE POLICY: (please initial) _____

If you have insurance benefits, we will gladly submit claims are your behalf. Your estimated copayment (the amount not covered by your insurance) for treatment is due at the time treatment is provided.

If you fail to provide the required insurance information, we will ask that you pay the bill in full at the time treatment is provided. If insurance is provided post procedure, and within the insurance company's statute of limitations, we will submit a claim on your behalf and reimburse once payments have been made.

As a courtesy, we will contact your insurance company, however, we are not responsible for inaccurate estimates (written or verbal) of coverage given to us by your insurance company. If coverage is denied, for any reason, you will be responsible for payment of the full cost of the treatment rendered and any outstanding amount.

Our office will not enter into a dispute with your insurance company over any claim. We will, however, provide the necessary documentation your insurance company requests to settle the claim.

APPOINTMENT POLICY: (please initial) _____

Operative rooms, instruments, and personnel are reserved exclusively for your appointment. There is a $50 charge for canceled, missed (No Show), or rescheduled appointments with less than 24 hours' notice. Repeated instances of failed appointments without 24 hours' notice will result in dismissal from the practice.

I have read, understood and agree to the terms and conditions stated in this policy.

Responsible Party Name: _____ Date _____

Responsible Party Signature: _____ Date _____

Patient Name (print): _____