Patient/Family Registration Form

Patient Name: _____DOB: _____Cell#_____

Patient Name: _____ DOB: _____Cell#_____

Patient Name: _____ DOB: _____Cell#_____

Patient Name: _____ DOB: _____Cell#_____

Patient Name: _____ DOB: _____Cell#_____

Address: _____City: _____ZIP: _____

Employer of Insurance Coverage: _____

Patient Treatment and Financial Policy:

The following is a statement of our Financial Policy by signing this form below you are agreeing to this policy.

- Payment for all services is due at the time the service is provided. Our office accepts cash, personal checks, MasterCard, Visa, Discover and American Express.

If you have Insurance:

- As a courtesy to you we will help you process all of your dental insurance claims. We will provide an insurance estimate to you. Please understand, it is not a guarantee that your insurance will pay exactly as estimated. Insurance coverage is subject to limitations, exclusions, waiting periods, frequency, age restrictions, deductibles, and maximums which are your responsibility.
- All Charges you incur are your responsibility, regardless of your insurance coverage. Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area.
- Deductible, co-payment and co-insurance which is the estimated amount not covered by your insurance company, is due at the time we provide the service(s) to you.
- Insurance payments are usually received within 10-45 days from the time of filing a claim. If your insurance company has not paid for the services after 60 days, we ask that you call your insurance to ensure the payment will be made. If payment is not received or is denied you will be responsible for paying the full amount at that time.
- We will fully cooperate with requests from your insurance company to help assist in claims being paid. However, our office will NOT dispute with your insurance company over a claim.

Missed Appointments:

Our goal is to provide treatment in a timely manner. In order to provide the best care for our patients we require at least 24-hour notice for any cancellations or for re-scheduling appointments. We understand that emergencies happen which may result in a cancellation or a missed appointment; however, if several appointments are missed or cancelled on short notice, a deposit may be required to schedule an appointment in the future.

Patient Signature: _____Date: _____

Patient Signature: _____Date: _____

All Adult patients and/or Insurance carriers on Account are required to sign this form.