Registration

General Dentist__________________________

Patients Name___________________________

Home Phone Number_____________________

Employed By_____________________________
PhoneNo.______________________Ext_______
Occupation______________Birthdate________
Home Address___________________________
(No P.O. Box)
City________________________Zip_________
Social Security No.______________________
If Student, Name of School_________________

Name of Spouse(or parent if minor)_________
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Employed by_____________________________
Phone No.______________________Ext_______
Occupation______________Birthdate________
Address_________________________________
City_______________________Zip__________
Social Security No.______________________

Has any family member been to this office before? _Yes _No

If patient is a minor, who is legally responsible for the fee?____________________________
Address of Person Responsible______________
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Phone No.____________________Ext________

Dental Insurance
Name of Policyholder_____________________
Name of Insurance Company________________
Policy No._______________Group No._______

Dual Insurance?
Name of Policyholder_____________________
Name of Insurance Company________________
Policy No._______________Group No._______

Name of Relative________________________

Phone Number___________________________

Name of Friend__________________________

Phone Number___________________________

Financial Policy

The mission of our office is to provide you with the highest quality dental care. Our service is based on a friendly, mutual, businesslike understanding between doctor and patient. We feel that misunderstandings can be minimized if financial policies are agreed upon at the beginning of treatment. The following statements are made to acquaint you with our policy:

a.There will be a consultation charge.

b.Fees quotes at the initial appointment will not increase; however, broken appointments or additional treatment may constitute an additional fee.

c.Our fee does not include the cost of a permanent restoration-to be done by your own dentist after your root canal has been completed.

d.All fees are payable at the time of treatment. We accept cash, personal check, all major credit cards and Carecredit. Upon credit approval, Carecredit offers both No-interest and Extended payment plans.

Please let us know if you have any concerns with regard to your financial responsibility.

Dental Insurance

All services rendered are charged directly to the patient who is then responsible for payment. If, however, we can verify insurance benefits, you will only be required to pay a deposit of one-half of the total fee on the day of treatment rather than pay in full. Your insurance company will pay a percentage of their own internal fee schedule. **The insurance company's allowed fees may be lower than our office fees.** We will bill your insurance company at no charge. If the insurance company pays more than your balance, we will **promptly** reimburse you. We do understand that many patients have more than 50% coverage with their insurance; however we must make you aware that many times endodontic care is not covered with the same benefits as general dentistry . Unless we have prior authorization or proof of exact coverage, the minimum down will be one-half the total fee. **Regardless of insurance coverage, any balance remaining in our office after 60 days is your responsibility. Therefore, if you have not heard from your insurance company in days, we suggest you contact them.** If you have any questions regarding insurance billing or financial policy, fee free to discuss this with a Care Coordinator.

Cash accounts 30 days overdue and insurance accounts 75 days overdue will be charged a late fee of $25.00.

Please sign after reading:

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