At your first appointment please provide your insurance card for us to copy. For your convenience, we will automatically process your claims for you. Thank you!

PLEASE FILL OUT FORM COMPLETELY AND ACCURATELY

Patient Registration Form

Last Name _____ First Name _____ Middle Initial _____

Nickname _____ Birth Date ____/____/____ Sex M/F _____

SSN # _____ E-Mail _____

Address _____ City _____ ST ____ Zip _____

Home # _____ Work # _____ Cell # _____

Employer _____ Address _____

Account Information (Responsible Party)

Last Name _____ First Name _____ Middle Initial _____

Mailing Address _____ City _____ ST ____ Zip _____

Home # _____ Work # _____

SSN # _____ Date of Birth _____

How do you plan to pay for today's services? ( ) Cash, ( ) Check, ( ) Credit Card

Payment Information

1. **Full payment at the time of service receives a discount of 5% for cash and check; 3% for MasterCard or Visa.**
2. **We accept Visa, MasterCard, Discover, and American Express.**
3. **If account becomes delinquent and is referred to an attorney for collection, patient agrees to pay all court costs and 25% Attorney fee on unpaid balance.**
4. **Statements are mailed in 30 day cycles. A service charge of 1.5% per month will be added to balances not paid within 60 days.**

Insurance Information

Insurance Company _____ Group # _____

Insurance Company Address _____

Policy Holder _____ Date of Birth ____/____/____

Policy Holder SSN _____ Employer Name _____

I hereby authorize the release of any information including the diagnosis and the records of any treatments or examinations rendered to my insurance company or companies. This release is solely for the purpose of facilitating the billing and reimbursement directly to the doctor or dentist of insurance benefits under which I am entitled.

"I understand and agree that I am ultimately responsible for any and all charges for services rendered by the practice. Dental insurance, to the degree that it is available, will offset amounts due. I understand verification of my insurance is my responsibility and that amounts due that are unpaid by the insurance company will be my responsibility. The practice is not a party to the contract between the insurance company and me, or the member of my family who is the primary subscriber."

Signature of Patient or Responsible party _____ Date _____