

PATIENT REGISTRATION

Last Name: _____ First Name: _____ Preferred Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ E-mail _____

Birthdate: _____ Sex: M or F Marital Status: M S D W Social Security #: _____

Employer's Name: _____ Occupation: _____

Address: _____ Work Phone: _____

Name of Spouse (or parent if minor): _____ Work Phone: _____

Employer Name and Address: _____

Person Financially Responsible for this Account

Name: _____ Relationship to Patient: _____

Address: _____ City: _____ State: _____ Zip: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Emergency Contact: _____ Phone: _____

How did you hear about our office? _____

Primary Dental Insurance Information

Insurance Company: _____ Group #: _____ Employer Name: _____

Subscriber Name: _____ Subscriber Social Security #: _____

Subscriber DOB: _____

Secondary Dental Insurance Information

Insurance Company: _____ Group #: _____ Employer Name: _____

Subscriber Name: _____ Subscriber Social Security #: _____

Subscriber DOB: _____

Financial Statement / Insurance Information

We are committed to providing you the highest quality dental care and assisting you with financial arrangements to receive the treatment you desire. In order to do this, we need your assistance in and understanding of our payment policy. We will gladly discuss treatment plans, payment options and answer any questions about your dental insurance.

Payment for services is due at the time service is rendered. For your convenience, we accept cash, VISA, MasterCard, Discover, American Express, and personal checks.

If you have dental insurance, we will assist you in receiving your maximum allowable benefits. We file all claims as a courtesy, however, you must understand that:

1. **Your insurance is a contract between you, your employer, and the insurance company.** We have chosen not to participate in any contracts with dental insurance because such contracts require dentists to provide services at less than the standard fee for the service. Your dental health and well being is our first priority, therefore we refuse to reduce the quality of products and services rendered to you. Please make sure that you are aware of the terms of your contract. If you have a change in insurance companies, please notify us immediately.

2. **Not all services are a covered benefit in all contracts.** Some insurance companies select certain services they will not cover.

3. **We ask that you pay your estimated portion the day that services are rendered.** Fees not paid by your insurance company after 45 days will become your responsibility.

If you have any questions about the above information, or any uncertainty regarding insurance coverage, please do not hesitate to ask us. We are here to help you.

I understand and agree to the following:

All of the above information is correct to the best of my knowledge. I will update Dr. Hall and / or staff to any changes.

I am responsible for the balance on my account and payment for all professional services rendered.

If I have dental insurance, I give Dr. Brad Hall and staff permission to submit necessary information to my insurance company for reimbursement.

Signature (Parent if minor)

Date

