# *Patient Registration*

**Patient (Or Responsible Party, If Patient Is A Minor)**

| | | | | | | |
|---|---|---|---|---|---|---|
| Last Name | First Name | | Initial | Preferred Name | Email | |
| Address | City | | State | Zip | Home Phone Number | |
| Birth Date Age | Occupation | | If Retired Previous Occupation | | Cell Phone Number | |
| Employer | Business Address | City | State | Zip | Work Phone Number | |
| Social Security Number | Drivers License Number | | Social History | | | |
| | | | Single | Married | Divorced | Widowed Separated |

**Spouse**

| | | | | |
|---|---|---|---|---|
| Last Name | First Name | Initial | Birth Date | |

Child **(If Child Is The Patient)**

| | | | | |
|---|---|---|---|---|
| Last Name | First Name | Initial | Preferred Name | Birth Date |

**Dental Insurance**

| | | | | |
|---|---|---|---|---|
| Insurance Name | Address | City | State | Zip |
| Policy Holder's Name | Policy Holder's S. S. Number | | Member Number | Group Number |
| Policy Holder's Employment | | | Birth Date | |

**Secondary Insurance**

| | | | |
|---|---|---|---|
| Insurance Name | Address | Policy Holder's S. S. Number | Group Number |

**Office Payment and Appointment Policy**

In providing complete dental care for our patients, we feel that it is important for our patients to completely understand their treatment and fees involved. For this reason the entire treatment plan is explained and appropriate fees discussed. The preparation and mailing of monthly statements is now very costly in any office, and usually results in higher fees for patients. As a result, this office has established the following fee-for-service office policy in order to avoid these additional costs:

1. Payment is expected at the time of service in cash, check or credit card.
2. For insurance patients, payment for the first appointment is expected unless the full extents of the insurance benefits are known.
3. **Twenty four hours notice is required if the appointment cannot be kept or a fee of $45.00 will be applied to your account.**

Most insurance coverage only pays a portion of the costs of such services that may be necessary. Most dental insurance programs have limited coverage and do not cover 100% of services. Insurance benefits will be collected from your insurance company and then you will receive a statement for the remainder. We urge you to be fully aware of the provisions of your policy.

Consent: I understand that responsibility for payment of dental services in this office for myself and my dependents is mine; due and payable at the time of services are rendered unless financial arrangements have been made. I understand that I am responsible for all costs of collection including attorney fees, collection fees and court costs. I understand that any unpaid balance will be assessed interest at the rate of 18.00% (1.5% monthly). Insurance claims are filed as a courtesy, but it is my responsibility to see that the claims are paid. I fully understand that I am responsible for payment of fees not covered by insurance. I also assign all benefits to Bruce H. Johnson. I authorize the submission of claims without obtaining my signature on each and every claim submitted and the release of x-rays and records to my insurance company as needed. I give my authorization and consent for treatment after having a full explanation of proposed treatment, alternatives, and rights by my doctor. I further consent to all diagnostic aids that are needed in order to complete a treatment plan. I have been advised of my privacy rights as provided by the Healthcare Information Portability and Accountability Act of 1996. I hereby authorize this provider and its employees, agents and assignees to contact me via e-mail, text messaging and to my cellular device. I have completed this form truthfully and completely to the best of my knowledge. I have read, understand and agree to abide by the policies of this office. I authorize this office to release x-rays and records to my insurance company as needed.

Signature_____ Date_____

I give my permission for the treatment of _____a minor, by our dentist and his/her staff under his/her supervision. Parent or guardian signature _____Relationship _____ Date_____