REGISTRATION FORM

Today's date:	Primary Dentist:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.:	Home/Cell phone no.: ( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Chose clinic because/Referred to clinic by (please check one box): ❑ Dr. ________ ❑ Insurance Plan ❑ Hospital

❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Other

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home/Cell phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance:

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Elison Dental Center or insurance company to release any information required to process my claims.

_______________________________ _______________

Patient/Guardian signature *Date*

HIPAA NOTICE OF PRIVACY PRACTICE

I have been given a copy of the HIPPA NOTICE OF PRIVACY PRACTICE.

Patient/Guardian signature *Date*

CONSENT FOR TREATMENT

I hereby authorize the doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by the doctor to make a through diagnosis of my dental needs. Upon, diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I agree to use of anesthetics, sedatives, and any other medication as necessary. I understand I can ask for a complete recital of any possible risk of complications.

Patient/Guardian signature *Date*

FINANCIAL INFORMATION

Deductible, co-payments, and any position not covered by your insurance is due at time of your visit. We accept cash, personal checks, Visa, MasterCard, Discover card, American Express, Money Order, Flex plan cards, and Care Credit. A $ 25 fee will be charged to the account for all returned checks and on accounts not paid by due date.

I have read and understand all stated financial policies of this office.

Patient/Guardian signature *Date*

OFFICE POLICIES

The office is open Monday-Thursday from 8-5:00, Friday 8-12:00. We require a 24 hour notice if you need to cancel an appointment. Anyone late 15 minutes for an appointment will not be seen that day and we reserve the right to charge a $45 fee. We guarantee all dental work for 2 years completed in our office. The only requirement is that you visit every six months for a check-up and cleaning.

Patient/Guardian signature *Date*