PATIENT REGISTRATION

Name of patient_____ Date_____

Date of Birth_____ Social Security Number_____

Address_____

Home Phone_____ Work Phone_____

Employer's Name_____

Employer's Address_____

Referred By_____

(If patient is a minor)

Parent's Name_____ Parent's SS#_____

Name of a friend or relative who can be reached in case of an emergency:

Name_____ Phone_____

Thank you for choosing us as your health care provider. We are committed to providing you with the best possible care. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy which we require that you read, agree to and sign prior to treatment.

REGARDING INSURANCE
For all treatment (excluding exams, x-rays and cleanings), we require a 25% co-payment at the time the services are rendered. The balance is your responsibility whether your insurance pays or not. We cannot bill your insurance unless you bring in all insurance information. Your insurance policy is a contract between you and your insurance company. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

PATIENT WITHOUT INSURANCE
Payment is expected at the time services are rendered. In cases where extensive treatment is necessary, we can discuss a payment plan.

MISSED APPOINTMENTS
Unless cancelled at least 24 hours in advance, a missed appointment will be considered a broken appointment. Patients demonstrating an inability to keep their appointments will no longer be given appointments. They will be seen on a call-in basis, as our schedule permits.

"I understand and agree that (regardless of my insurance) I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on this sheet."

_____ _____

Signature of Patient Date Person Responsible for Payment