PATIENT REGISTRATION

Date _____

Last Name_____ First Name_____ Middle Initial_____

Preferred Name_____ Male_____ Female_____

Address_____

City/State/Zip_____

Date of Birth_____ Age_____ Married_____ Single_____ Child_____ Widowed_____

Social Security No._____ Driver's License No._____

Phone Numbers: Home (_____)_____ Business (_____)_____ Cell(_____)_____

E-mail Address:_____

Occupation_____ Employer_____

Business Address_____

If Child – Mother's Name_____ Date of Birth_____

Father's Name_____ Date of Birth_____

If Married – Spouse's Name_____ Date of Birth_____

Business Phone (_____)_____ Social Security No._____

Occupation_____ Employer_____

Business Address_____

Full-time Students: School_____

Dental Insurance Information

Primary Carrier_____ Group #_____

Primary Carrier's Address_____

Primary Carrier's Phone No._____

Policy Holder_____ Social Security No._____

Policy Holder's Address_____

Policy Holder's Date of Birth_____ Policy Holder's Phone No._____

Please Help Us

Is another member of your family or relative a patient at our office: Yes____ No_____

Name_____ Relationship_____

How did you learn about our practice? ____Mail ____Phone Directory ____TV ____Other:_____

____ Referred by Doctor (name) _____

____ Referred by a family member (their name) _____

____ Referred by a friend (their name)

____ Referred by a friend (their name) _____

____ Magazine (which one) _____

Person to contact for an emergency _____

Relationship _____ Home Phone (____)_____ Work Phone(____)_____

[Please carefully read and sign other side]

CONSENT FOR TREATMENT

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

Signature of Patient, Parent, or Responsible Party_____ Date_____

FINANCIAL POLICIES

I understand that:

- **FULL** payment is due at the time of service.
- **All charges are ultimately the responsibility of the patient/guarantor (regardless of insurance).**
- A third party (with the exception of insurance companies) will not be billed for any amount due this office. Custodial parents are guarantors for children; this office is not a party in domestic settlements.
- Any fees quoted for this office's treatment plans will be honored for 12 months (excludes insurance pre-estimates).
- In the event payment is not made by the due date, a late charge and/or a rebilling fee may be added to the patient's account.
- Any collection fees incurred by this office in an attempt to obtain payment, or bank fees for a returned check, or **fees for an appointment missed or broken with less 48 hours' notice will be paid by the patient/guarantor**.

(ADDITIONAL POLICIES PERTAINING TO INSURANCE)

I understand that:

- This office files **only** with the **primary** insurance carrier.
- **The patient/guarantor is responsible to pay for all services rendered on their behalf if insurance does not pay within 60 days of date of service.**
- Any deductible and/or co-payment is due at time of service.
- This office is not contracted with any insurance carrier as a networked provider. Therefore, any fee or portion of a fee not covered by insurance is the patient's/guarantor's responsibility to pay. Acceptance of insurance assignment of benefits to this office does not absolve the patient of full responsibility of payment for treatment rendered. Any estimate given by this office regarding insurance portions is only a guideline until the final insurance payment is received and the patient's account has been reconciled. This office makes no guarantee of the insurance payment as estimated.
- Any patient/guarantor whose insurance carrier does not honor assignment of benefits to the provider of service must pay this in full at the time services are rendered. This office can file the claim and the patient/guarantor will receive payment from insurance. This policy also applies to all Federal employee insurance plans.

I certify that I have read and do hereby agree to the above stated financial policies of this office.

Patient_____ Date_____

Parent or Responsible Party_____ Relationship to Patient_____

INSURANCE SIGNATURE AUTHORIZATION

I hereby authorize this dental office to release to my insurer any information necessary to obtain payment to benefits on insurance claim for me, my spouse, or my dependents.

I hereby authorize payment of my dental insurance benefits, otherwise payable to me, to the dentist.

Signature of Insured Person_____ Date_____

Smiles for the Family
350 Newnan Crossing Bypass
Newnan, GA 30265
770-252-1300