Patient Registration/Office Policy Date:

First Name: _____ Last Name: _____ Middle Initial: ____

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

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Date of Birth: _____ Social Security #: _____ Sex: M F

Email Address:

Responsible Party (complete only if patient is under 18)

First Name: _____ Last Name: _____ Middle Initial: ____

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

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Date of Birth: _____ Social Security #: _____ Sex: M F

Email Address:

Emergency Contact Name: _____ Phone number: _____

How did you hear about us? (Circle one) Insurance Website Mailer Internet Yellow Pages eDentist.com
Friend or Relative:_____ Other: _____

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: Self Spouse Child Other

Insured Soc. Sec. _____ Insured DOB: _____

Employer: _____-_____ Insurance Company: _____

Insurance Company Address: _____

City, State, Zip:

**If you have Secondary Insurance, please inform the receptionist.

Financial Policy:

PAYMENT IS DUE AT THE TIME OF SERVICE. The full balance of treatment is due at the time of service is rendered. Payment plans are available through Care Credit and we also accept cash, check, Visa, MasterCard, Discover.

Assignment of Dental Insurance Benefits – Our office files insurance benefits as a courtesy to you. Claims unpaid by your insurance company after 60 days are your responsibility and will be due in full. All deductibles, copayments, and non-covered fees are due at the time of service. A CURRENT copy of your insurance card must be kept on file to utilize this service. Our office reserves the right to discontinue and/or refuse to file claims.

Service Charges – A $25 fee will apply to all returned checks. A fee of $50 will be charged for appointments cancelled with less than 24 hour notice. Our office reserves the right to pursue any other remedy by law.

Delinquent Accounts – Account balances exceeding 90 days may be pursued through third party collection agencies at the account holder's responsibility at a charge of 8% interest.

Authorizations:

I affirm that the information given is correct to the best of my knowledge. It will be held in confidence and it is my responsibility to inform the office of any change of address, employment, insurance information, and medical status. I authorize the release of all information necessary to secure benefits otherwise payable to me. I assign directly to Fallston Family Dentistry all insurance payments otherwise payable to me. I understand that I am responsible for the full balance, including but not limited to third party collection fees, court fees, filing fees, and attorney fees.

I authorize the dental staff to perform all necessary dental treatment needed. Like any treatment of the body, there are certain risks, benefits, limitations, and alternatives to treatment and no guarantee of the outcomes or cures will be given. I understand it is difficult to predict any symptoms, if any, I may encounter as a result of treatment.

I affirm that my signature represents my agreement to all the above mentioned terms.

Signature of Patient, Parent, or Guardian: _____