

PATIENT REGISTRATION

*** This is a legal document. Please complete it fully and accurately ***

Today's Date _____ Patient Social Security # _____

First name _____ MI _____ Last name _____

Gender: Male Female Date of Birth _____ Age _____

Employer _____ Occupation _____

Home Address: _____ Home Phone _____

City _____ Work Phone _____

State _____ Zip _____ Cell Phone _____

Email: _____ Referred by _____

Emergency Contact _____ Phone _____

PERSON RESPONSIBLE FOR BILL

Name _____ Phone _____

Address _____ Drivers License # _____

City _____ State _____ Zip _____ Social Security # _____

DENTAL INSURANCE INFORMATION

Insurance Information

1. Primary Insurance

2. Secondary Insurance

| Insurance Information | 1. Primary Insurance | 2. Secondary Insurance |
|--|----------------------|------------------------|
| Insurance Name | | |
| Subscriber's Name | | |
| Subscriber's Employer | | |
| Subscriber's Work Phone # | | |
| Subscriber's ID # or Soc. Sec. # | | |
| Group Number | | |
| Subscriber's Birthdate | | |
| Subscriber's Address (if different from patient) | | |
| Subscriber's Phone (if different from patient) | | |
| Relation of Subscriber to Patient | | |

Student Status, if applicable: Full-Time Student Part-Time Student

SEE PAGE 2 ON REVERSE SIDE

FINANCIAL INFORMATION

Taking care of you and your family is our highest priority. That is why, when it comes to talking about finances, our goal is to provide you with clear information regarding our dental fees and your payment options. At the onset of treatment, we will provide you with an *estimate* of the fees expected. Treatment needs can change for a variety of unforeseen reasons. Whenever possible, we will inform you of any treatment changes that will affect your financial estimate.

When estimating insurance coverage, we must also stress the word *estimate* as dental benefits are determined by each patient's dental contract. Most dental insurance plans are designed to *assist* patients with their dental expenses. Very few dental plans fully cover all dental services.

As a courtesy to you, we will file your insurance forms, but we do not accept responsibility for collecting your insurance claim or negotiating a settlement on a disputed claim. Insurance coverage, reimbursement, and benefits are a contract between you and your insurance carrier.

Please read and initial each statement and date below. If you have any questions regarding any of this information, *please* ask us-we are here to help you.

_____ I acknowledge & understand that I am ultimately responsible for knowing and understanding my dental insurance benefits.

_____ My estimated portion & co-payments for services rendered are due at the time of service unless prior arrangements have been made with one of our Financial Specialists.

_____ I understand that I am responsible for the prompt payment of my account regardless of any pending insurance claim or settlement.

_____ I understand that the Treatment Plan provide to me is for my future treatment needs and is only an estimate regarding my insurance benefits. I am responsible for all charges not paid by insurance, including finance charges.

_____ I acknowledge & understand that Family First Dental is a Preferred Provider for Washington Dental Service, Oregon Dental Service, Delta Dental Service, Assurant, Aetna, MetLife, and Premera Blue Cross ONLY. It is my responsibility to know if my insurance company requires me to see one of their Preferred Providers.

_____ I acknowledge & understand that even if I have dual insurance coverage, there may be instances where the two insurances will not pay 100%. In such cases, I am responsible for any amount not paid by insurance(s).

_____ An 18% annual finance charge will be applied to any balance on accounts that are 90 days past due (even if the balance is unpaid insurance claims). Monthly finance charges are 1.5%, with a monthly minimum of .50.

_____ I will receive a confirmation call at least 2 days in advance of my appointment. I understand that there is a cancellation fee of \$25-\$50 for appointments cancelled or broken without 48 hours notice.

I have read all the information on both sides of this sheet and the information I have provided is true and correct to the best of my knowledge. I will notify your office of any changes to my personal information, insurance plan and/or health status.

Signature _____ Date _____

Person signing is the: Patient Parent Guardian Other