DENTAL EXCELLENCE OF
Hatfield

## PATIENT REGISTRATION

**Patient Name:** _____ __Married __Divorced __Single __Other
Address: _____City:_____State:____Zip:_____
Home #: _____Cell #: _____Email address: _____ Employer:
_____ SS#_____ Work #: _____

**Spouse Name:** _____ __Married __Divorced __Single __Other
Address (if different):_____City:_____State:____Zip:_____
Home #: _____Cell #: _____Email address:_____ Employer:
_____ SS#_____ Work#:_____

### PRIMARY DENTAL INSURANCE

Policy Owner's Name: _____DOB: _____
ID #/Social Security #: _____Group/Policy #: _____
Dental Insurance Plan Name: _____
Claims Address:_____
Employer: _____
Insurance Co. Phone#:_____
Relationship to patient:_____

### SECONDARY DENTAL INSURANCE

Policy Owner's Name: _____DOB: _____
ID #/Social Security #: _____Group/Policy #: _____
Employer: _____
Dental Insurance Plan Name: _____
Claims Address:_____
Insurance Co. Phone#:_____
Relationship to patient:_____

### REFERRAL & PHARMACY INFORMATION

Whom may we thank for referring you to our office?

Referring Doctor/Office (Name): _____ Current Patient (Name): _____
Family Member (Name): _____

Drive By ____ Google _____ Website _____ Facebook _____ Twitter _____ Facebook _____ Other _____

Pharmacy name:_____Phone #:_____
Emergency contact (not living with you) :_____Phone #:_____

### CONSENT FOR SERVICES

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are performed. Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that she/he is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 90 days, unless previously written financial arrangements are satisfied. I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient's examination. All fees associated with collections and/ or Attorneys cost will be your responsibility. The undersigned hereby authorizes the doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's needs. I grant permission to you or your assignee to telephone me at home and leave a messsage. I give my authorization to transfer any records or radiographs to another provider for treatment of my child. I understand that it is my responsibility to advise your office of any changes in the information contained in this form.

I have read the above conditions of treatment and payment and agree to their content.

Signature:_____ Date: _____