PATIENT REGISTRATION

Welcome to our office. We are pleased that you have chosen us to assist you with your dental care. In order to care for you and communicate better, please fill out both sides of this form completely.

1 About You

Today's Date: _____

Name: Mr. Mrs. Ms. Dr. _____
(LAST) (FIRST) (MI)

I prefer to be called: _____

Birthdate: _____ Age: _____ S.S. # _____

Home Address: _____

City: _____ State: _____ Zip: _____

❑ Male ❑ Female ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Home Phone #: _____ Cell #: _____

Work Phone #: _____ Ext: _____ E-mail: _____

Preferred method of contact: ❑ Text ❑ Email ❑ Phone Call

Employer: _____

Employer's Address (City): _____

Occupation: _____

Is another family member or relative a patient in our office? _____

Name: _____ Relationship: _____

2 About Your Spouse

His/Her Name: _____

Employer: _____ Occupation: _____

Work Phone #: _____ Ext: _____

3 Account Information

Person Financially Responsible for Account: _____

Relation to Patient: _____ S.S. #: _____

Billing Address: _____

Work Phone #: _____ Ext: _____ Home Phone #: _____

Employer: _____

4 Emergency Contact

In the event of an emergency, whom should we contact?

His/Her Name: _____ Relation: _____

Phone #: _____

5 Referral Source

Our practice is fortunate to receive referrals from friends (patients and colleagues) who have been pleased with the services that we provide. Whom may we thank for referring you to us? _____

6 Dental Insurance

Does your employer provide dental insurance? ❑ Yes ❑ No

Are you eligible for direct reimbursement benefits? ❑ Yes ❑ No

Ins. Co. Name: _____

Ins. Co. Address: _____

Ins. Co. Phone #: _____

Group #: _____

Name of Policy Holder: _____ Relation: _____

Birthdate of Policy Holder: _____ Insured's S.S. #: _____

Insured's Employer: _____ Date Employed: _____

The services that we provide for you are based on an agreement between you and our office. Your dental insurance relationship constitutes an agreement between you, your employer and your insurance carrier. Please carefully review our policy regarding dental insurance and your responsibilities as the insured. Our dental team is here to help you and will be happy to answer any questions that you may have.

7 Financial Responsibility

I understand that the responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. In the event of default, I promise to pay legal interest (1 1/2% per month - 18% per annum), together with any collection costs and attorney fees as may be required to effect collection of this note.

I hereby authorize payment of my dental insurance benefits directly to Hayes Barton Dentistry. I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services and I understand that I am financially responsible for payments in full of all accounts by signing this agreement.

_____ Date: _____ Relationship to patient: _____

Signature of patient, parent, or guardian

_____ Date: _____ Relationship to patient: _____

Signature of guarantor of payment/responsible party