PATIENT REGISTRATION

Schultz Family Dentistry

TODAY'S DATE: _____ / _____ / _____

FULL NAME: _____ **PREFERRED NAME:** _____

PATIENT IS: ☐ Responsible Party ☐ Policy Holder ☐ Dependent (check all that apply)

PATIENT INFORMATION:

Address:_____

City, State, Zip:_____

Birth Date:_____ / _____ / _____ Social Security #: _____-_____-_____

Sex: ☐ Female ☐ Male Employer: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Please fill out **ALL** contact numbers and email. Check the BEST methods to contact you (check all that apply):

☐ Cell Phone: (_____) _____ - _____ ☐ Work Phone: (_____) _____ - _____

☐ Home Phone: (_____) _____-_____ ☐ Email: _____

RESPONSIBLE PARTY (if someone other than the patient):

Full Name: _____

Relationship to patient: _____ Has Existing Account at this office? Yes / No

Address: _____

City, State, Zip: _____

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

Birth Date:_____ / _____ / _____ Social Security #: _____-_____-_____

INSURANCE INFORMATION:

PRIMARY INSURANCE

Name of Insured: _____

Insured Social Security #: _____-_____-_____

Insured Birth Date: _____ / _____ / _____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other

Employer: _____

Insurance Company: _____

Insurance Co. Phone #: _____

Address: _____

City, State, Zip: _____

Group #: _____

ID #: _____

SECONDARY INSURANCE

Name of Insured: _____

Insured Social Security #: _____-_____-_____

Insured Birth Date: _____ / _____ / _____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other

Employer: _____

Insurance Company: _____

Insurance Co. Phone #: _____

Address: _____

City, State, Zip: _____

Group #: _____

ID #: _____

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PATIENT REGISTRATION

Schultz Family Dentistry

EMERGENCY CONTACT:

Name:_____

Relationship:_____ Phone Number:_____

Physician's Name and Phone Number:_____

Preferred Pharmacy Name and Phone Number:_____

CLOSEST RELATIVE NOT LIVING WITH YOU:

Name:_____

Relationship:_____ Phone Number:_____

Address:_____

City, State, Zip:_____

OTHER INFORMATION:

Is another member of your family a patient at our office? ☐ Yes ☐ No

If yes, Name:_____ Relationship_____

How did you decide to join our family of dental patients?

☐ Personal referral--Who may we thank for referring you?_____

☐ Phone Book ☐ Newspaper or Magazine

☐ Insurance Company ☐ Other--Please list:_____

CONSENT FOR TREATMENT/ INSURANCE ASSIGNMENT/ FINANCIAL RESPONSIBILITY/ OFFICE POLICIES:

1) I hereby authorize the doctor or designated staff to take radiographs (x-rays), study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of this patient's dental needs. I authorize the doctor, following appropriate diagnosis, to perform all recommended treatment mutually agreed upon by the patient, or representative of the patient, and the doctor.
2) I agree to the use of anesthetics or other medications as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of these risks.
3) I hereby authorize Schultz Family Dentistry to furnish information to insurance carriers concerning my dental needs and treatment, and I hereby assign to Schultz Family Dentistry all payments for services rendered to my dependants or myself. I understand that I am ultimately responsible for full payment of all charges, and Schultz Family Dentistry makes no guarantees of my insurance reimbursement.
4) I understand that I am financially responsible for any and all unpaid amounts incurred in treatment. I understand that accounts that are 30 days past due are subject to a minimum service charge of $5.00 or 2.5% of the outstanding balance per month, whichever is greater.
5) I understand that if my account remains unpaid and is forwarded to a collection agency, I will be responsible for any reasonable collection costs, including reasonable attorney fees. I understand that, if required, a check of my credit history may be made.
6) I understand that, if required/ necessary, a check of my credit history may be made.
7) I understand that in the event that my check is returned to Schultz Family Dentistry from the bank, I will be charged $30.00. I understand that I will be required to pay the amount of the original check plus the service fee within five business days by cashier's check, money order, cash, or credit card. If I fail to do this, my account may be turned over to a collection agency.
8) I understand that a minimum of 24 hours notice is required for cancellation of appointments. A broken appointment fee may be charged to my account and is payable by me if a 24 hour notice is not given.

Patient/Gaurdian Signature:_____ Date:_____

Responsible Party's Signature:_____ Date:_____
(if different than patient)

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