REGISTRATION 2015

Today's Date _____

Patient's Name _____ Home Ph_____

Address _____ Cell Phone_____

City/Zip____ _____ Work Phone_____

Birthdate_ _____ Social Security # _____

If Patient is a child:

Mom's Name _____ Address _____

Birth Date_____SS# _____ Home Phone _____

Cell Phone _____ Business Phone_____

Dad's Name _____ Address _____

Birth Date _____SS#_____ Home Phone _____

Cell Phone _____ Business Phone _____

Who will be responsible for this account?

Do you have MVP Health Care for medical insurance? Yes No (If yes, please provide card to receptionist)

Do you have Dental insurance? Yes No If no, how do you intend to pay? Check Cash Credit Card

Dental Insurance Company_____ Plan Name/Category# and Subscriber ID#_____

Subscriber Name _____Subscriber Social Security # _____

Subscriber B'date _____ Subscriber Employer _____

Do you have secondary insurance? Yes No If yes, please provide subscriber information below

Dental Insurance Company _____Plan Name or Category # _____
(GHI & CSEA patients)

Subscriber Name _____Subscriber Social Security #_____

Subscriber B'date _____Subscriber Employer _____

Please provide receptionist with all insurance cards

CONSENT

I certify that I have read and understand all practice policies issued to me and posted within the office. I authorize the Doctor to take x-rays, study models, photographs, or any diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of my dental needs. I also authorize Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. **I understand that my dental insurance is a contract between me and the insurance carrier, and not between the insurance carrier and the Doctor and that I am still fully responsible to all dental fees. These fees are due and payable at the time services are rendered unless prior financial arrangements have been made. I also assign all insurance benefits to the Doctor. Any payments received by the Doctor from my insurance coverage will be credited to my account, or refunded to me if I have paid the dental fees incurred. I further understand that there will be a charge to me for any "no show" appointments or cancellations less than 48 hours before appointment. I understand that where appropriate, credit reports may be obtained or affected for non payment of services.**

PATIENT Signature (Parent of Child) _____Date_____