DENTAL REGISTRATION

PATIENT INFORMATION

Date: ______________

Patient name ______________________________

Address ______________________________

City ______________________________

State ______________ Zip ______________

Social Security Number _____ ______________

Sex M F Date of Birth ______________

Married Single Minor Other

Occupation ______________________________

Patient Employer ______________________________

Patients work Phone Number ______________

Spouse's Name ______________________________

Spouse's Date of Birth ______________________

Spouse's Employer ______________________________

Whom may we thank for referring you?

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Home phone __________ work ______________

Cell phone ______________________________

e-mail ______________________________

Emergency contact ______________________________

Phone number ______________________________

Consent for treatment
I give my consent to any advisable and necessary dental procedures, medications, or anesthetics to be administered by the attending dentist or by the supervised staff for diagnostic purposes or dental treatment.

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Signature of Patient, parent or guardian Date

Assignment and Release
I certify that I, and/or my dependents have insurance coverage and I assign directly to the dentist all insurance benefits, if any, otherwise payable to me for services rendered. I authorize use of my signature for all insurance submissions.

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Signature of Patient, parent or guardian Date

DENTAL INSURANCE

Who is responsible for this account? ______________

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Relationship to patient? ______________________

Insurance Co ______________________________

Group number ______________________________

Subscriber name ______________________________

Birthday ______________ SS# ______________

Is patient covered by additional insurance?

Subscriber name ______________________________

Birthday ______________ SS# ______________

Relationship to patient? ______________________

Insurance Co ______________________________

Group number ______________________________

Financial Policy /Appointment Policy
I understand that I am financially responsible for all charges whether or not paid by insurance. Accounts over 90 days due will be sent to collections and courtesy credits no longer valid. In the event I default, I agree to pay a collection fee of 40% of the principle balance, attorney fees, and all legal costs incurred.

We value your time and would like to reserve appointments that work well with your schedule. We reserve time exclusively for you. If a conflict arises with your reserved time, please kindly give Hover Dental Group 48 hours (2 business day, not including weekends) notice. However, we do understand that an occasional emergency can occur. A fee of $50 per hour will be charged to your account if adequate notice is not given.

By my signature, I acknowledge that I have read and agree to the above.

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Signature of patient, parent or guardian Date

HIPPA Consent
The dentist may use my healthcare information and may disclose such information to the insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

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Signature of patient, parent or guardian Date