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?

_____

How would you prefer we contact you regarding your appointments?

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.

_____

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.

_____

Signature of Patient, parent or guardian Date

DENTAL INSURANCE

Who is responsible for this account? _____

_____

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

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. 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 kinkly give Hoer Dental Group 48 hours (2 business days, not including weekends) notice. A fee of $50 per hour reserved will be charged to your account if adequate notice is not given. We do, however, understand that an occasional emergency may occur and those situations will be considered on a case by case basis and at times the fee waived.

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

_____

Signature of patient, parent or guardian

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.

_____

Signature of Patient, parent or guardian Date