

PATIENT REGISTRATION

TODAY'S DATE
WHO MAY WE THANK FOR YOUR REFERRAL?
WHAT IS YOUR RELATIONSHIP WITH THIS REFERRAL?

YOUR NAME	SPOUSE'S NAME
BIRTHDAY	BIRTHDAY
S.S. #	S.S. #
MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>	MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>
MARITAL STATUS	MARITAL STATUS
CELL PHONE	CELL PHONE
HOME PHONE	HOME PHONE
ADDRESS	ADDRESS
CITY STATE ZIP	CITY STATE ZIP
E-MAIL ADDRESS	E-MAIL ADDRESS
OCCUPATION	OCCUPATION
EMPLOYER	EMPLOYER
ADDRESS	ADDRESS
CITY STATE ZIP	CITY STATE ZIP
BUS. PHONE	BUS. PHONE

LIST CHILDREN IN THE FAMILY

NAME	BIRTHDATE
NAME	BIRTHDATE
NAME	BIRTHDATE
NAME	BIRTHDATE

EMERGENCY CONTACT PHONE
ADDRESS CITY STATE ZIP

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of the patient) _____'s dental needs.
2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
4. I release clinical and restorative dental photos taken by Brent A. Engelberg, D.D.S., P.C. and I understand that photos may be used by Brent A. Engelberg, D.D.S., P.C. for teaching, publications, and for patient education.
5. Lastly, I understand and agree that any collection or legal fees incurred by Brent A Engelberg, D.D.S., P.C., in an effort to collect debts I owe, will be my responsibility.

Patient _____ Date _____ Witness _____

Patient or Responsible Party _____ Relationship to patient _____

INSURANCE/FINANCIAL POLICIES

PRIMARY INSURANCE _____ _____	SECONDARY INSURANCE _____ _____
INSURANCE COMPANY NAME _____ _____	INSURANCE COMPANY NAME _____ _____
INSURED _____ _____	INSURED _____ _____
GROUP NUMBER _____ _____	GROUP NUMBER _____ _____
MEMBER ID _____ _____	MEMBER ID _____ _____
CLAIMS ADDRESS _____ _____	CLAIMS ADDRESS _____ _____
CITY _____ _____	CITY _____ _____
STATE _____ ZIP CODE _____	STATE _____ ZIP CODE _____
INSURANCE PHONE _____ _____	INSURANCE PHONE _____ _____

PAYMENT PLANS WILL BE BASED UPON THE PRIMARY INSURANCE PAYMENT. SECONDARY INSURANCE WILL BE SUBMITTED WHEN PAYMENT OBLIGATION IS COMPLETED BY PRIMARY INSURANCE CARRIER AND PATIENT.

STATEMENTS ARE MAILED EACH MONTH. PAYMENTS NEED TO BE RECEIVED BY THE DUE DATE UNLESS OTHER ARRANGEMENTS ARE MADE IN ADVANCE.

ANY CHECKS RETURNED WILL BE CHARGED A \$25.00 SERVICE FEE.

WE REQUIRE 24 HOUR NOTICE FOR ANY CHANGES OR CANCELLATIONS TO YOUR APPOINTMENT OR YOUR ACCOUNT MAY BE ASSESSED A FEE.

I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON MY BEHALF OR MY DEPENDENTS. I UNDERSTAND THAT PAYMENT IS DUE AT THE TIME OF SERVICE, UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE.

IN THE EVENT PAYMENTS ARE NOT RECEIVED BY AGREED UPON DATES, I UNDERSTAND THAT 1½% / MONTH LATE CHARGE (18%APR) WILL BE ADDED TO MY ACCOUNT.

Patient _____ Date _____ Witness _____

Patient or Responsible Party _____ Relationship to patient _____