NEW PATIENT REGISTRATION

PATIENT INFORMATION (*CONFIDENTIAL*)

Name _____ SSN _____ Today's Date _____
(First) (Middle Initial) (Last)

Address _____ City _____ State _____ Zip _____

E-Mail _____ Birthdate _____

Work # _____ Home # _____ Cell # _____

(Check one) ____ Minor ____ Single ____ Married ____ Divorced ____ Widowed ____ Separated

Spouse/Guardian Name _____

If College Student: Full-time / Part-Time Name of School _____

Whom may we thank for referring you to our practice? _____

Emergency Contact: Name _____ Phone Number _____ Relationship _____

Preferred contact method (Check one) _____ Cell # _____ Home # _____ Work # _____ Email

Appointment Preferences: **DAY** (Circle all that apply) **Mon Tues Wed Thurs** TIME _____

RESPONSIBLE PARTY – (Person responsible for payment)

Name _____ **Relationship *to Patient*** _____

Address _____

Driver's License _____ State _____ Birthdate _____

Is this person currently a patient in our office? _____ Yes _____ No

DENTAL INSURANCE CARRIER INFORMATION (Please ensure that you are providing information for your DENTAL carrier and not your MEDICAL carrier)

Insured Person's LEGAL Name _____ ***Relationship to Patient*** _____

Birthdate _____ SS# / Subscriber ID# (as displayed on your ID card) _____

Employer _____ Work # _____

Insurance Carrier _____ Phone # _____ Group # _____

Claims Address _____ City _____State ____ Zip _____

*** REGARDING SECONDAY DENTAL INSURANCE :**

We will provide you with the documentation needed to file any secondary claims. However, the Patient Portion for treatment ***(your out-of-pocket/coinsurance amount)*** is estimated based on ***PRIMARY CARRIER COVERAGE ONLY.***

Patient/Guardian Signature _____ Date _____

Southlake Periodontics & Implant Dentistry Financial Policy and Cancellation Policy

Payment is due at the time services are rendered. We accept cash, personal checks, cashier's checks, money orders, Visa, Mastercard, Discover, American Express, and Care Credit. Returned checks will be subject to additional fees.

For patients who carry dental insurance:** As a courtesy to you, we will help you process all your insurance claims. We ask that you pay the deductible and co-payment, which is the ***estimated amount not covered by your insurance company at the time we provide service to you. We must emphasize that this is only an **estimate** and all charges you may incur are your responsibility regardless of your insurance coverage. Insurance companies have a wide variety of rules, plan limitations and exclusions that our office may not be aware of. Dental insurance is a benefit for the patient provided by their employer and the contract lies between the patient, employer and the insurance company. Our office is not a party to that contract. We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. However, this office will not enter into a dispute with your insurance company over any claim. Once insurance has paid their share, a statement will be sent to you for any remaining balance and will be due upon receipt. If your insurance company has not made payment within 60 days, the unpaid balance becomes your responsibility and is subject to finance charges and the collection process.

Separated & Divorced Couples with Dependent Children: It is the policy of this office to bill the parent that brings the children in for their dental treatment. Please make arrangements for payment from an ex-spouse before dental treatment is rendered. We can provide a treatment cost estimate before your scheduled appointment.

Cancellation & Late Policy: Your appointment time is reserved for you. If you are late for your appointment, we may not be able to accommodate you. If you think that you will be late, please call as soon as possible so that we may advise you if your late arrival can be accommodated, or if we will need to reschedule you. We maintain a very strict schedule and must insist that appointment times be respected. For cancellation we require 24 hours advanced notice. Our voicemail system available for messages left after business hours.

CONSENT: I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO MY DENTAL OFFICE. The undersigned hereby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's 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 responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered. I further understand that a finance, rebilling, collection charge or attorney fee will be added to any overdue balance.

_____ _____

Signature (Patient or responsible party) Date