ADULT REGISTRATION

TODAY'S DATE: ________________

****

PLEASE FILL OUT COMPLETELY

If a question does not pertain to you, please indicate by entering N/A (Not Applicable) in the blank space.

****

PATIENT'S INFORMATION

NAME: ____

How would you like to be addressed by the staff?

____

DATE OF BIRTH:___/ ____/ ____ SS# ___-__- _____

ADDRESS: ____

____

HOME PHONE: (____) ______ - ____________________

CELL NO.: (____) ______ - ______________________

EMPLOYER: ____________________________________

BUSINESS ADDRESS: ___________________________

____

BUSINESS PHONE: (_____) ______-________________

POSITION HELD: _______________________________

SPOUSE'S INFORMATION (when applicable)

NAME: ____

How would you like to be addressed by the staff?

____

DATE OF BIRTH: ____/ ___/ _____ SS# __-___-_______

ADDRESS: ______________________________________

____

HOME PHONE:(_____) ____-_______________________

CELL NO.: (____) ______-________________________

EMPLOYER: ____________________________________

BUSINESS ADDRESS: ___________________________

____

BUSINESS PHONE: (____) ______-___________________

POSITION HELD:_________________________________

****

PERSON FINANCIALLY RESPONSIBLE FOR THIS ACCOUNT

RELATIONSHIP TO PATIENT: self _______ spouse ______ other (please specify) ________________________

IN CASE OF AN EMERGENCY, WHO SHOULD BE NOTIFIED?________________________PHONE: (___) ____- _____

WHOM SHOULD WE THANK FOR REFERRING YOU? ____

****

PRIMARY INSURANCE (when applicable)

EMPLOYEE: ____________________________________

INSURANCE COMPANY:__________________________

INSURANCE ADDRESS: __________________________

____

INS. TELEPHONE: (____) ______-_________________

GROUP POLICY #:______________________________

EFFECTIVE SINCE: _____________________________

SECONDARY INSURANCE (This only applies if you are covered by a second dental insurance company)

EMPLOYEE: ____________________________________

INSURANCE COMPANY: __________________________

INSURANCE ADDRESS: __________________________

____

INS. TELEPHONE: (____) _______-_________________

GROUP POLICY #:_______________________________

EFFECTIVE SINCE: _____________________________

Please Complete Back →

STATEMENT OF RESPONSIBILITY AND CONSENT

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

The Office Financial Policy is that we ask for payment at the time service is rendered. For those individuals who have insurance, this office will submit to all insurance companies and will only ask for the portion which your insurance is ***not estimated*** to cover at the time service is performed. If there is a difference in our estimate and what your insurance company actually covers, as sometimes happens, we will bill you for the difference. In the case of procedures which have a higher fee, such as crowns, bridges, and dentures, a short-term payment arrangement ***may*** be allowed.

I understand and acknowledge that I am financially responsible for the services provided for myself and/or the above named, regardless of insurance coverage. I have had the office financial policy explained to me and understand the guidelines of that policy.

____ Date: ________________

(SIGNATURE OF RESPONSIBLE PERSON)

Spouse, if applicable ____ Date: ________________

(SIGNATURE OF RESPONSIBLE PERSON)

****

ASSIGNMENT OF INSURANCE BENEFITS

ORDER TO PAY INSURANCE:

TO:____________________________________ GROUP POLICY #:__________________

(INSURANCE COMPANY)

I hereby authorize and request your company to pay directly to Gentle Dental Care, P.C. the amount due me under terms of my policy issued by your company. Payment is authorized upon your receipt of each itemized statement for services rendered me or my family members covered by the same policy. Said payment, in whole or in part, shall be the same as if paid directly to me.

____ Date: ________________

(SIGNATURE OF INSURED)

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