

Patient Registration/Financial Policy

Date: _____

First Name: _____	Last Name: _____	Middle Initial: _____
Preferred Name: _____	Parent/Legal Guardian(s) if under the age of 18: _____	
Address: _____	City: _____	State: _____ Zip: _____
Home Phone: _____	Work Phone: _____	Cell Phone: _____
Birth Date: _____	Social Security #: _____	
Sex: <input type="radio"/> M <input type="radio"/> F	Marital Status: <input type="radio"/> Married <input type="radio"/> Single <input type="radio"/> Divorced <input type="radio"/> Separated <input type="radio"/> Widowed	
Emergency Contact Name and Number _____		

How did you hear about us? Insurance Website Internet HomePages Friend or Relative _____

Primary Dental Insurance Information

Name of Insured: _____	Relationship to Insured: <input type="radio"/> Self <input type="radio"/> Spouse <input type="radio"/> Child <input type="radio"/> Other
Insured Soc. Sec. _____	Insured DOB: _____
Employer: _____	Insurance Company: _____
Address: _____	Address: _____
Address 2: _____	Address 2: _____
City, State, Zip: _____	City, State, Zip: _____
Employment Status: <input type="radio"/> Full Time <input type="radio"/> Part Time <input type="radio"/> Retired	

****If you have Secondary Insurance, please inform the receptionist.**

Financial Policy:

- **PAYMENT IS DUE AT THE TIME OF SERVICE.** The full balance of treatment is due at the time service is rendered. Payment plans are available through Care Credit and we also accept cash, check, Visa, MasterCard, Discover, and American Express.
- **Assignment of Dental Insurance Benefits –** Our office files insurance benefits as a courtesy to you. Claims unpaid by your insurance company after 60 days are your responsibility and will be due in full. All deductibles, copayments, and non-covered fees are due at the time of service. A CURRENT copy of your insurance card must be kept on file to utilize this service. Our office reserves the right to discontinue and/or refuse to file claims.
- **Service Charges –** A \$25 fee will apply to all returned checks. A fee of \$50 will be charged for appointments cancelled with less than 24 hour notice. Our office reserves the right to pursue any other remedy by law.
- **Delinquent Accounts –** Account balances exceeding 90 days may be pursued through third party collection agencies at the account holder’s responsibility at a charge of 8% interest.

Authorizations

I affirm that the information given is correct to the best of my knowledge. It will be held in confidence and it is my responsibility to inform to office in any changes of address, employment information, insurance information, and medical status. I authorize the release of all information necessary to secure benefits otherwise payable to me. I assign directly to Eriks Dental all insurance payments otherwise payable to me. I understand that I am responsible for the full balance, including but not limited to third party collection fees, court fees, filing fees, and attorney fees.

I authorize the dental staff to perform all necessary dental treatment needed. Like any treatment of the body, there are certain risks, benefits, limitations, and alternatives to treatment and no guarantee of the outcomes or cures will be given. I understand it is difficult to predict any symptoms, if any, I may encounter as a result of treatment.

I affirm that my signature represents my agreement to all the above mentioned terms.

Signature of Patient, Parent, or Guardian: _____