REGISTRATION

PATIENT'S NAME ______________________

IF CHILD, PARENT'S NAME ______________________

HOW DO YOU WISH TO BE ADDRESSED ______________________

❑ SINGLE ❑ MARRIED ❑ SEPARATED ❑ DIVORCED ❑ WIDOWED ❑ MINOR

ADDRESS ______________________

CITY ____________ ST. ______ ZIP ________

BUS. ADDRESS ______________________

TEL. RES. ____________ BUS. ____________

CELL ____________ EMAIL ____________

PATIENT/PARENT EMPLOYER ______________________

PRESENT POSITION ____________ HOW LONG HELD ____

SPOUSE/PARENT EMPLOYER ______________________

PRESENT POSITION ____________ HOW LONG HELD ____

WHO IS RESPONSIBLE FOR THIS ACCT. ____________

(OR GUARDIAN) ______________________

DRIVER'S LIC. # ______________________

METHOD OF PAYMENT: ❑ CREDIT CARD ❑ CHECK ❑ CASH

BUDGET PLAN WITH PRIOR APPROVAL ❑

PURPOSE OF CALL ______________________

OTHER FAMILY MEMBERS IN THIS PRACTICE ____________

____

WHO MAY WE THANK FOR THIS REFFERRAL ____________

____

PATIENT/ PARENT SSN. ______________________

SPOUSE/PATIENT SSN. ______________________

DATE ________ DATE OF BIRTH ___/___/___ ❑ MALE ❑ FEMALE

DENTAL INSURANCE 1ST COVERAGE

EMPLOYEE NAME ______________________

EMPLOYEE DATE OF BIRTH ______________________

EMPLOYER ______________________ # YRS. ______

NAME OF INSURANCE CO. ______________________

ADDRESS ______________________

____

PHONE ______________________

PROGRAM OR POLICY # ______________________

UNION LOCAL OR GROUP ______________________

SOCIAL SECURITY # ______________________

DENTAL INSURANCE 2ND COVERAGE

EMPLOYEE NAME ______________________

EMPLOYEE DATE OF BIRTH ______________________

EMPLOYER ______________________ # YRS. ______

NAME OF INSURANCE CO. ______________________

ADDRESS ______________________

____

PHONE ______________________

PROGRAM OR POLICY # ______________________

UNION LOCAL OR GROUP ______________________

SOCIAL SECURITY # ______________________

SOMEONE TO NOTIFY IN CASE OF EMERGENCY NOT LIVING WITH YOU ______________________

RELEASE

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits plus credit review.

I authorize release of any information concerning my (or my child's) health care, advice and treatment to another dentist.

I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.

I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services. I understand that I am solely financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by my dental care payor.

I understand that accounts over 60 days will incur a 1.5% finance charge per month and I will be responsible for all collection charges.

I specifically agree to cooperate to submit to dentist all correspondence received from dental insurer, medical insurer or other payor, detailed explanation of benefits (E.O.B.) received with the check in payment thereof or denials of benefits as well as the check or draft. (This correspondence is needed for claim documentation.)

I attest to the accuracy of the information on this page.

PATIENT'S or GUARDIAN'S SIGNATURE ______________________ **DATE** ____________

RELATIONSHIP OF GUARDIAN ______________________

Louis Sandor Jr. DDS, PA **Barry L. Sandor DMD**