

PATIENT REGISTRATION

Today's Date: _____

Last Name: _____ First: _____ MI _____ ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr.

Street Address: _____ City: _____ St: _____ Zip: _____

MAILING ADDRESS IF DIFFERENT: _____

Phone: Home () _____ Work () _____ EXT _____ Cell () _____

NICKNAME: _____ Email: _____

Sex: ☐ M ☐ F SS# _____ Date of Birth: ____/____/____

Employer & Address: _____

Referred By: _____ General Dentist: _____

***WE ARE NOT MEDICARE PROVIDERS. PLEASE DO NOT BILL MEDICARE FOR THESE SERVICES.

PAYMENT OPTIONS (NO CHECKS, Please)

Cash or Debit Cards – Payment in full is required the day of service/treatment.

Major Credit Cards – We accept most major credit cards for your convenience.

Care Credit – You may want to apply and take advantage of this dedicated dental credit card.

---- Root Canal Treatment, surgical or non-surgical, runs between \$1,125.00 - \$1,895, when complex ----

Delta Dental Insurance & Cigna "RADIUS" Network Insurance – Co-pay and deductible are due on the day of service.

Your signature to release information and assign benefits is required. Secondary insurance (other than Delta & Cigna) is your responsibility to bill. We will provide the necessary information to assist you with this.

Other Insurance – Payment in full is required the day of service/treatment. We will be happy to bill your insurance for you if all of the necessary information is provided to us. Any money sent to us, erroneously, by your insurance company will be deposited, as addressed, and then promptly paid to the subscriber.

DENTAL INSURANCE INFORMATION

Every individual dental insurance policy, purchased by you or for you, is unique in their terms of agreement. As a courtesy to our patients we will bill your dental insurance for you, however, **you are responsible for the entire cost of treatment.** Contact your insurance company to answer any questions you may have in regards to their reimbursement guidelines. Please pay special attention to any deductibles owed or mention of "usual and customary fees" since these amounts vary considerably within the same geographic region from one company to another.

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PRIMARY CARRIER (Please present your card)

Policy Holder/Subscriber _____

Employed by: _____

Member ID or

Subscribers DOB: _____ SS # _____

Insurance co.: _____

Address: _____

Phone # _____ Group # _____

SECONDARY CARRIER

Policy Holder/Subscriber _____

Employed by: _____

Member ID or

Subscribers DOB: _____ SS #: _____

Insurance co.: _____

Address: _____

Phone # _____ Group # _____