

# Patient Registration

<b>Patient's Name</b>		Sex: M F	Birth date	Age	Today's Date
Home Address			City	State	Zip
Please Circle One: Single, Married, Separated, Widow			Occupation	Home Phone Number	
Your Employer		How Long Employed	Your Soc Sec. #	Work Phone	
Are you a full time student? Yes No		<i>If patient is minor we need:</i>	<i>Mother's Birth date:</i>	<i>Father's Birth Date</i>	
<b>Person responsible for account</b>			Driver's license number		
Name of spouse (Parent if minor)		E-mail address:		Cell Phone	
Spouse's (parent's) employer		Spouse's Soc. Sec. #		Work phone	
<b>How did you hear about our office?</b>			<b>EMERGENCY INFORMATION</b>		
Reason for this visit			Name, Address, & telephone of _____		
			A Relative Not living with you. _____		

DENTAL INSURANCE INFORMATION (Primary Carrier)			If you have a dual insurance coverage, complete this section ( Secondary Ins)		
Insured's name	DOB	SS#	Insured's name	DOB	SS#
Insured's employer			Insured's employer		
Insurance Co			Insurance Co		
Insurance Co Address			Insurance Co Address		
Phone #			Phone #		
Group #	Local #		Group #	Local #	

## FINANCIAL POLICY

Thank you for choosing McCordsville Family Dentistry as your dental health care provider. We are committed to providing you with the highest quality dental care, so that you may fully attain optimum oral health. Please understand that payment of your bill is considered part of your treatment.

**Payment is due at the time service is provided.** Our office accepts cash, personal checks, MasterCard, Visa, and Discover as well as **CareCredit: If you would like more information about this financing option please check here:**

**Please Note:** Returned checks will be subject to additional fees. In the case it becomes necessary for our office to enlist a collection service and/or legal assistance; you will be responsible for all collection and/or legal charges incurred.

**All appointments require 48 hour advance notice if not able to be kept. Otherwise a fee of \$25 will be charged and collected before rescheduling future appointments.**

### ***Do You Have Insurance?***

- ♣ As a courtesy we will submit your insurance claim(s) for you. Please understand that we will provide an insurance estimate to you; however please realize this is just an estimate. Your insurance company, along with your plan benefits ultimately determines the amount paid.
- ♣ All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company. Our office is not a party to that contract.
- ♣ Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.
- ♣ We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office.
- ♣ We ask that you pay the deductible and co-payment, which is the estimated amount, not covered by your insurance company, by cash, check, credit card or CareCredit at the time we provide the service.
- ♣ Insurance payments are ordinarily received within 60 days from the time of filing. If your insurance company has not made payment within 60 days, we will contact them to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.
- ♣ We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.

We thank you for the opportunity to serve your dental health care needs and welcome any questions you may have concerning your care or our financial policy.

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.

PATIENT Signature (Parent of Child) \_\_\_\_\_ Date: \_\_\_\_\_