Date_____

PATIENT REGISTRATION

Patient Name_____ _____
First Middle Last

Address_____ _____

City_____State_____ _____Zip_____

Home Phone_____Work_____Cell_____Text __**Yes / No**_____

Employer_____Occupation_____

DOB_____Social Security #_____Drivers Lic #_____

Marital Status_____Sex_____E mail Address_____

Who may we thank for referring you?_____

RESPONSIBLE PARTY:

Name:_____Employer_____

Phone_____Social Security #_____DOB_____

Insurance:

Dental Insurance Carrier_____

Policy Holder Name_____ID #_____DOB_____

Pref Dentist_____Pref Pharmacy_____

FINANCIAL ASSIGNMENT AND AGREEMENT:
I HEREBY AUTHORIZE PAYMENT DIRECTLY TO DETNAL WEST OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL COSTS OF DENTAL TREATMENT. I HEREBY AUTHORIZE DENTAL WEST TO ADMINISTER SUCH MEDICATIONS AND PERFORM SUCH DIAGNOSTIC, PHOTOGRAPHIC AND THERAPEAUTIC PROCEDURES AS MAY BE NECESSARY FOR PROPER DENTAL CARE. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payers and/or health professionals. (If you would like a copy of our Privacy Practices, please inform the receptionist.)

PAYMENT IS DUE AT THE TIME OF SERVICE. If insurance fail to pay, any remaining balance will be billed. If I do not pay the entire new balance within 30 days of the monthly billing date, a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate of 1.5% per month, which is an annual percentage rate of 18% applied to the last month's balance. In the case of default of payment, I promise to may any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred for collection of this account or future out standing accounts.

Signature **Date**