## Patient Registration

Date_____

Patient Name_____
First Middle Last

Address_____

City_____State_____Zip_____

Home Phone_____ Cell _____Work_____

Employer_____Occupation_____

Date of Birth_____ Social Security No._____Sex_____

Marital Status_____ E mail Address_____Drivers Lic #_____

**Complete if under 18 years or a student:**

Name of Father_____Employer_____

Phone_____work_____SSN_____DOB_____

Name of Mother_____Employer_____

Phone_____work_____SSN_____DOB_____

**Insurance:**

Dental Insurance Carrier:_____

Policy Holder Name_____ ID #_____

Pref Dentist_____Pref Pharmacy_____

FINANCIAL ASSIGNMENT AND AGREEMENT:
I HEREBY AUTHORIZE PAYMENT DIRECTLY TO DENTAL WEST OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL COSTS OF DENTAL TREATMENT. I HEARBY AUTHORIZE DENTAL WEST TO ADMINISTER SUCH MEDICATIONS AND PERFORM SUCH DIAGNOSTIC, PHOTOGRAPHIC AND THERAPEUTIC 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 fails 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 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 pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

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Signature Date