

Patient Registration

First name: _____ Last name: _____ Middle Initial: _____

If minor, name of parent(s): _____

How would you like to be addressed? _____

Birth Date: _____ Age: _____ Soc. Sec: _____

Address: _____

City, State, Zip: _____

How do you prefer being contacted by our office? (Please check preference)

Home phone : (____) _____ - _____ Work phone: (____) _____ - _____ Cell: (____) _____ - _____

Email address: _____

Sex: Male Female Marital Status: Married Single Divorced Separated Widowed

Name of Employer: _____

Someone to notify in case of an emergency: _____ Phone: _____

Who referred you to our office? _____

Insurance Information (please provide insurance card)

Name of Policy Holder: _____ Policy Holder Birth Date: _____

Relationship of Patient: Self Spouse Child Other _____

Subscriber ID # _____ Group # _____

Name of Policy Holder's Employer: _____

Name of Insurance Company: _____ Phone: _____

Address: _____ City, State, Zip: _____

Cancellation Policy:

If you fail to show for an appointment, cancel, or reschedule less than 24 hours prior to your scheduled appointment time, our office reserves the right to charge your patient account a fee of \$40.00.

Financial Policy:

I hereby authorize West End Dental to furnish information to insurance carriers concerning my treatment, and I authorize insurance benefit payments directly to West End Dental. I understand that I am financially responsible for the payment of all services rendered. West End Dental charges 1.5% (18% annual interest, minimum of \$3.00/month) on accounts with a balance 90 days past due.

I attest to the accuracy of the information on this page. I agree to the cancellation and financial policy.

Signature _____ **Date** _____