west end dental
comprehensive & aesthetic dentistry

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: _____

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:

We begin preparing for your visit two days before your arrival. This is why we have a strict two business day cancellation policy for patients. The only exception is for Monday appointments which may be cancelled by 4pm on the prior Friday without incurring penalty. Patients who cancel without sufficient notice more than once within a twelve month period will be required to pay a refundable deposit of $50.00 to hold any scheduled appointments. The deposit will be applied to payment due or refunded on the day of appointment. If the deposit has not been paid two business days before your scheduled appointment, it will be cancelled. If you cancel less than 2 business days before the pre-paid appointment, West End Dental reserves the right to keep the deposited amount.

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**_____