

PATIENT REGISTRATION APEX DENTAL

PATIENT INFORMATION

PATIENT'S NAME Last _____ First _____ Middle Initial _____ SEX: M F BIRTHDATE _____ AGE _____
 Soc. Sec. # _____ If Patient is a Minor, give Parent's or Guardian's Name _____ TODAY'S DATE _____
 Who May We Thank for Referring You to our Office? _____ Reason for this Visit _____

RESPONSIBLE PARTY INFORMATION

NAME Last _____ First _____ Middle Initial _____ MARITAL STATUS _____
 RESIDENCE Street _____ Apt # _____ City _____ State _____ Zip _____
 MAILING ADDRESS Street _____ Apt # _____ City _____ State _____ Zip _____
 HOW LONG AT THIS ADDRESS _____ HOME PHONE _____ CELL PHONE _____
 WORK PHONE _____ EMAIL _____
 PREVIOUS ADDRESS (if less than 1 yr.) Street _____ City _____ State _____ Zip _____ How Long _____
 SOCIAL SECURITY # _____ BIRTHDATE _____ DRIVER'S LICENSE # _____ RELATION TO PATIENT _____
 EMPLOYER _____ OCCUPATION _____ NO. YEARS EMPLOYED _____

RESPONSIBLE PARTY'S SPOUSE

NAME _____
LAST FIRST MIDDLE
 EMPLOYER _____ OCCUPATION _____
 SOC. SEC. # _____ BIRTHDATE _____
 HOME PH. _____ CELL PH. _____
 WORK PH. _____ E-MAIL _____

EMERGENCY CONTACT INFORMATION:

NAME _____ RELATIONSHIP _____
 ADDRESS _____ CITY, STATE _____
 HOME PH. _____ CELL PH. _____
 WORK PH. _____

DENTAL INSURANCE INFORMATION (Primary Carrier)

Insured's Name _____
 Insurance Co. _____ E-MAIL _____
 Insurance Co. Address _____
 Insured's Employer _____
 Insured's Soc. Sec. # _____ Group # _____

If you have double dental insurance coverage, complete this for the second coverage.

Insured's Name _____
 Insurance Co. _____ E-MAIL _____
 Insurance Co. Address _____
 Insured's Employer _____
 Insured's Soc. Sec. # _____ Group # _____

Do you REGULARLY use DENTAL FLOSS? Yes No

NAME OF PREVIOUS DENTIST?

City: _____ State: _____ phone#: _____

Date of last exam/cleaning:

PHARMACY YOU PREFER TO USE?

PATIENT Signature (Parent of Child) _____ Date: _____ DENTIST Signature _____

If you are the parent,(guardian) bringing the child you are the responsible party for treatment rendered

FINANCIAL POLICY / HIPAA LAW

Thank you for choosing us for your dental care provider. Our office is committed to providing you with the highest quality dental care and personalized services. Please understand that payment for services is considered part of your treatment. The following is a statement of our Financial Policy that we require you to read and sign prior to any treatment. All patients must complete the required office forms and method of payment must be established before seeing the doctor.

Regarding payment

Payment is due at the time services are rendered unless prior arrangements have been made with the doctor.

If you have dental insurance, we will file your claim for you. If there is a balance after your insurance pays, we will send you a statement. After 60 days you are responsible for full payment on your account, regardless of your insurance company's coverage. (see below)

We accept the following forms of payment: Cash, check, Visa/MasterCard and CareCredit.

If dentures, partial dentures, crowns and bridges are to be fabricated by a dental laboratory, a deposit is due at the time of the first impression. The remaining balance is due at the time the prosthesis is cemented, inserted or delivered.

Checks that are returned to our office from your financial institution are subject to a \$20 returned check fee. This fee covers the processing fees that are charged to our office.

Regarding Insurance

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. In the event we do accept assignment of benefits and your insurance company has not paid your account in full, the balance will be billed to you.

Please be aware that some, and perhaps all, of the services provided may not be non-covered services and not considered reasonable and customary under the terms of your insurance policy. Insurers' determination of usual and customary rates and coverage are generally arbitrary and not based on the usual and customary fees for our area. 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 your insurance company's coverage. Please get a benefits booklet from you Human Resources to help you understand your benefits.

Your complete insurance information must be presented at the time services are provided. Insurance claims cannot be backdated. Most benefits will be verified before your insurance company can be billed. We will need a copy of your dental insurance card in addition to identifying information such as the policy holder's social security number and insurance ID number in order to file the claim with your insurer as well as your Drivers Lic.

All insurance co-pays and deductibles must be paid at the time of service.

We will be happy to discuss our charges and how they relate to your particular situation. We also realize that temporary financial situations may affect timely payment of your account. If such problems arise, we encourage you to contact us promptly for assistance in the management of your account. In the event your account goes to a collection agency you will be responsible for fees incurred.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns. I have read Apex Dental's Financial Policy. I understand and agree to this Financial Policy.

Signature of Patient or Responsible Party: _____ Date: _____

Printed Name of Patient or Responsible Party: _____

We request that our patients *call our office* at least 48 hours prior to their scheduled time to cancel an appointment. Appointments that are cancelled with less than 48 hours notice are considered a Broken Appointment and may be subject to a cancellation fee.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES (HIPAA)

I hereby acknowledge that I have access to Apex Dental's (Dr. Michael Harms') Notice of Privacy Practices.

Signature: _____ Date _____