Patient Registration Form

Personal Information

Responsible Party ____
First Name Middle Initial Last Name

Patient ____
First Name Middle Initial Last Name

Address ____

City ______________________ State ______________ Zip ______________

Patient's Birthday_________________ Email Address ______________________

Home Phone ______________ Work ______________ Cell ______________

Best way for us to reach you during business hours that allows you to respond: Preferred time:
☐ Email ☐ Home Phone ☐ Work Phone ☐ Cell Phone ☐ Text AM or PM or Both

Preferred pronoun? ☐ She/her/hers ☐ He/him/his ☐ They/them/theirs ☐ Other:______________

How did you hear about us?____

Insurance Information (Unless provided previously. If you do not know the following information please contact your insurance company)

Subscriber's Name ______________________ DOB __________

Subscriber's Social Security/ID # ______________ Insurance Company______________

Insurance Phone number ______________ Group Number ______________

Employer's Name ______________________ Phone number ______________

<u>We do require 2 business days for any appointment changes.</u> Dental insurance plans do not normally provide full coverage of your dental bill. Your dental coverage is a contract between you and your insurance company, and while we will cooperate to the fullest in expediting your claim, you are ultimately responsible for your account. <u>Your portion of the bill will be due at time of service.</u> If your insurance has not paid within 60 days from the date from the date of service, we will look to you for prompt payment of the account. Accounts not paid within 60 days are subject to 1.5% monthly interest charge. All costs for collection of the account, should collection procedures or small claims court become necessary, will be passed on to the patient and/or the responsible party.

I hereby authorize and direct payment of dental benefits otherwise payable to me, directly to City Smiles. I understand and agree to the above financial policies. I understand that, due to any false information, I will be subject to criminal prosecution.

______________________ ______________________________________

Date **Signature of patient (responsible party of minor)**