PATIENT REGISTRATION INFORMATION

Welcome to our practice!
Thank you for selecting our dental healthcare team. Please fill out this form completely in ink. If you have any questions or concerns, please do not hesitate to ask for assistance – we will be happy to help!

Name_____ ( )married ( )single ( )minor ( )male ( )female
. *First* *Middle* *Last*
Home address_____City_____State_____Zip_____
Birthdate_____ Age_____Social Security #_____E-mail address_____
Place of Employment_____If full time student, name of school_____
Home Phone_____Work Phone_____Cell Phone_____
Whom may we thank for referring you to our office?_____ Previous Dentist_____
Medical doctor_____ Pharmacy_____
In case of emergency contact: Name_____Relationship_____
Address_____Phone _____

Responsible Party (if different than above)
Name of responsible party_____
. *First* *Last* *Relationship*
Address _____
Birthdate_____ Home Phone_____Driver's License #_____Social Security #_____
Employer_____Work Phone_____

Dental Insurance Information
Name of Insured_____
. *First* *Last* *Relationship*
Birthdate_____Social Security #_____Employer ID#_____
Employer_____Work Phone_____Insurance Company_____
Insurance Company Address_____Group #_____Phone #_____
If you have **secondary dental insurance**:
Name of insured_____
. *First* *Last* *Relationship*
Birthdate_____Social Security #_____Employer ID#_____
Employer_____Work Phone_____Insurance Company_____
Insurance Company Address_____Group #_____Phone#_____

A billing charge of 1.5% monthly (minimum $3.00 charge) is assessed on balances over 60 days

I acknowledge that I am financially responsible for all charges. If it becomes necessary to commence collections of any amount owed on this and subsequent visits, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees. I understand that missed or canceled appointments without at least two business days prior notification may result in a broken appointment fee up to $50 per hour of the scheduled appointment time. I authorize Dr. Carlish to bill my insurance. I authorize release of any needed information and assign benefits to be payable to Dr. Carlish.

Name_____Signature_____Date _____