ALL SMILES
FAMILY DENTISTRY
EST. 1993

# Patient Registration

**Patient Information**

First Name: _____ Last Name:_____ Middle Initial: _____

Preferred Name: _____

Address: _____ Address 2: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Sex: Male ____ Female ____ Marital Status: Single _____ Married _____ Divorced _____ Separated _____

Birth Date: _____ Age: _____ Social Security #: _____

Email: _____ **Who REFERRED you to our office** : _____

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**Responsible Party (if other than the patient)**

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ Address 2: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Birth Date: _____ Age: _____ Social Security #: _____

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**Acknowledgement of Receipt of Notice of Privacy Practices**

I, _____, acknowledge that I was offered a copy of this office's Notice of Privacy Practices.

Signature: _____ Date: _____

**Primary Insurance Information**

Name of Insured: _____Relationship to Insured: ___Self ___Spouse ___Child ___Other___

Insured Soc Sec:_____ Insured Birth Date: _____

Employer:_____

Insurance Company: _____

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**Secondary Insurance Information**

Name of Insured: _____Relationship to Insured: ___Self ___Spouse ___Child ___Other

Insured Soc Sec:_____ Insured Birth Date: _____

Employer:_____

Insurance Company: _____

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**Financial Policies**

Responsible parties agree to pay for services rendered the day of treatment. Our methods of payment are: Cash, Check, Credit Card, Money Order, and Care Credit (with no interest…ask for details).

**We file insurance as a courtesy to our patients.** We ONLY file 2 insurances. It is the patient's responsibility to know and understand your insurance benefits. However, Dr. Meyer will recommend the needed treatment for our patients as we do not allow insurance companies to dictate your health care needs. **You, the patient, are responsible for contacting your insurance provider about non-payment, delays in payment and reduced payment.**

We ask that you make every effort to keep your appointments. Missing an appointment disrupts proper sequencing of care, delays completion of treatment and affects our ability to schedule another patient at that time. Also, if you are more than 15 minutes late to an appointment, we may have to reschedule you to be courteous to our other patients in the schedule.

***We do ask for a 48- hour notice if you need to cancel or change your appointment. Upon review, we reserve the right to assess a $35 fee for "no shows" and cancellations.***

There will be a $45.00 service charge for returned checks.

I agree to the above and acknowledge that I was offered a copy of All Smiles financial policy.

Signature: _____ Date:_____