Patient Registration/Financial Policy Date: ________________

First Name: ______________________ Last Name: ______________________ Middle Initial: _________

Preferred Name: __________________ Parent/Legal Guardian(s) if under the age of 18: _______________

Birth Date: ____________________Social Security #: _____________________ Sex: Male Female

Address: ________________________________City/State: _________________________Zip: ______

Home Phone: ____________________Work Phone: ______________________Cell: _________________

Email: _______________________________Marital Status: Married Single Divorced Separated Widowed

Emergency Contact Name and Number: ____

How did you hear about us? Insurance Internet/website Referred by family/friend:_____________________

Primary Dental Insurance Information

Name of Insured: __________________________ Relationship to Insured: Self Spouse Child Other

Insured Social Security #: _____________________Insured DOB: ______________________________

Employer: ________________________________ Insurance Company: _________________________

Address: _________________________________ Address: __________________________________

City/State/Zip:______________________________ City/State/Zip: _____________________________

Employment Status: Full Time Part Time Retired

*****If you have Secondary Insurance, please inform the receptionist**

Financial Policy

• PAYMENT IS DUE AT THE TIME OF SERVICE. The full balance of treatment is due at the time service is rendered. Payment plans are available through Care Credit and we also accept cash,check, Visa, Mastercard, and Discover.

• Assignment of Dental Insurance Benefits – Our office files insurance benefits as a courtesy to you. Claims unpaid by your insurance company after 60 days are your responsibility and will be due in full. All deductibles, co-payments, and non-covered fees are due at the time of service. A CURRENT copy of your insurance card must be kept on file to utilize this service. Our office reserves the right to discontinue and/or refuse to file claims.

• Service Charges – A $25 fee will apply to all returned checks. A fee of $75 will be charged for appointments canceled with less than 24 hour notice. We request this 24 hour notice as a courtesy, it makes it possible to give your reserved room to another patient who may need it. **Repeated cancellations or missed appointments will result in loss of future appointment privileges.**

• Delinquent Accounts – Account balances exceeding 90 days may be pursued through third party collection agencies at the account holder's responsibility.

Authorizations

I affirm that the information given is correct to the best of my knowledge. It will be held in confidence and it is my responsibility to inform the office of any changes of address, employment information, insurance information, and medical status. I authorize the release of all information necessary to secure benefits otherwise payable to me. I assign directly to **Evergreen Prosthodontic Associates, LLC** all insurance payments otherwise payable to me. I understand that I am responsible for the full balance, including but not limited to third party collection fees, court fees, filing fees, and attorney fees. I affirm that my signature represents my agreement to all the above mentioned terms.

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Signature of Patient, Parent, or Guardian **date**