



# PATIENT REGISTRATION

## 1. PLEASE TELL US A BIT ABOUT YOURSELF. YOUR ANSWERS ARE COMPLETELY CONFIDENTIAL.

DATE		NAME (LAST, FIRST, M.I.)		PREFERS TO BE CALLED	
COMPLETE ADDRESS (STREET, CITY, STATE, ZIP)					
HOME PHONE		CELL PHONE		E-MAIL	
BIRTHDATE		AGE		SOCIAL SECURITY NUMBER	
GENDER (CIRCLE ONE)		MALE FEMALE		MARITAL STATUS (CIRCLE ONE)	
				MARRIED SINGLE DIVORCED WIDOWED	
IS ANOTHER MEMBER OF YOUR FAMILY A PATIENT AT OUR OFFICE? IF SO, PLEASE INDICATE BELOW: NAME:			RELATIONSHIP:		
YOU WERE REFERRED TO US BY			HOW DID YOU HEAR ABOUT US?		
IN THE EVENT OF AN EMERGENCY, PLEASE CONTACT			TELEPHONE		RELATIONSHIP TO PATIENT
COMPLETE ADDRESS OF EMERGENCY CONTACT (STREET, CITY, STATE, ZIP)					
PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT (IF NOT YOU)			RELATIONSHIP TO PATIENT		SOCIAL SECURITY NUMBER
COMPLETE ADDRESS OF FINANCIALLY RESPONSIBLE PARTY (STREET, CITY, STATE, ZIP)					

## 2. IF THIS APPOINTMENT IS FOR YOUR CHILD, PLEASE COMPLETE THIS SECTION. IF NOT, CONTINUE ON TO SECTION 3.

DATE		NAME (LAST, FIRST, M.I.)		PREFERS TO BE CALLED	
COMPLETE ADDRESS (STREET, CITY, STATE, ZIP), IF DIFFERENT FROM ABOVE					
HOME PHONE		CELL PHONE		E-MAIL	
BIRTHDATE		AGE		SOCIAL SECURITY NUMBER	
GENDER (CIRCLE ONE)		MALE FEMALE		SCHOOL	
				GRADE	

### 3a. PRIMARY DENTAL INSURANCE CARRIER.

### 3b. SECONDARY INSURANCE CARRIER (IF APPLICABLE).

INSURANCE COMPANY		GROUP NUMBER		INSURANCE COMPANY		GROUP NUMBER	
EMPLOYER NAME		INSURED'S NAME		EMPLOYER NAME		INSURED'S NAME	
DATE OF BIRTH		RELATIONSHIP TO PATIENT		DATE OF BIRTH		RELATIONSHIP TO PATIENT	
INSURED'S IDENTIFICATION NO.		INSURED'S SOCIAL SECURITY NO.		INSURED'S IDENTIFICATION NO.		INSURED'S SOCIAL SECURITY NO.	

## 4. CONSENT FOR TREATMENT.

1. I hereby authorize Dr. Boardman or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by Dr. Boardman to make a thorough diagnosis of the above-named patient's dental needs. Upon such diagnosis, I authorize Dr. Boardman and/or her staff to perform all recommended treatment mutually agreed upon by me and to employ such assistance as is required in order to provide proper care.
2. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
3. I give consent to the doctor's or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.
4. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event that payments are not received by agreed-upon dates, I understand that charges may be applied to my account as outlined in a separate financial agreement. I also understand that, if required, a check of my credit history may be made.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Witness: \_\_\_\_\_

Parent/Responsible Party's Signature: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

# REBECCA BOARDMAN, D.D.S.

COMPREHENSIVE RESTORATIVE DENTISTRY

## OUR FINANCIAL POLICY

### Uninsured Patients

For patients without dental insurance, or patients whose insurance benefit maximum has been met or exceeded for the contract year, full payment is due at time of service, including any past-due balance. We accept cash and checks, as well as Visa, Mastercard, Discover and American Express cards.

### Insured Patients

For patients with active insurance coverage, we will submit your claim for services rendered, then bill you for any remaining balance your provider did not cover.

The remaining balance due after an insurance claim has been settled is your responsibility *whether your insurance company pays or not*. Some or even all of the services provided may be non-covered and not considered reasonable and necessary by your insurance company. Your insurance policy is a contract between you and your insurance provider, and reimbursement levels are dependent upon the premiums you pay, the benefits your company negotiates, and frequency limitations. We are not a party to that contract.

If your insurance company has not paid on a submitted claim within 60 days, you will be responsible for the total amount of your balance and it will become your responsibility to collect any unpaid benefit from your insurance company. Any amount insurance pays to our office that you have already paid will be refunded to you or, if you wish, will be credited to your account to be applied to future treatment.

Please note that, in order to bill your insurance company properly, we must have your complete and accurate insurance information and be kept up-to-date regarding any changes to this information.

Please note that any insurance benefit figure provided by our office is an *estimate* only. Contact your dental insurance provider with any questions regarding your coverage, and request a pre-treatment estimate of coverage before embarking on any potentially costly treatment.

### Usual and Customary Rates

We charge what is usual and customary for prosthodontic practices in our area. You are responsible for payment regardless of what an insurance company may define as "usual and customary fees."

### Missed Appointments

Because office time and materials are reserved for you, a fee may be assessed for a missed appointment not canceled at least 24 hours in advance. The first such fee will be \$40.00; subsequent fees will be charged at our current hygiene rate. Please help us serve our patients efficiently by keeping your scheduled appointments or giving us as much advance notice as possible of a conflict in your schedule.

### Delinquent Accounts

We appreciate payment within 30 days of billing statement receipt. Payments received later than 30 days are subject to a monthly 1.5% finance charge (\$3.00 minimum). Accounts over 90 days past-due are subject to submission to a collection service, which may adversely affect your credit rating. We reserve this as a final collection measure after all other attempts have been exhausted.

**Our practice is committed to providing the best possible dental and oral health care and making your visit with us as enjoyable as possible. Please feel free to discuss any questions or concerns you have regarding the above.**

I have read, understand, and agree to this Financial Policy.

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Signature of responsible party

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Date