PATIENT REGISTRATION FORM

Patient Name_____ Social Security #_____

Address_____City_____State_____ZIP_____

Home Phone_____Cell_____Work_____

Birthdate_____ Female or Male Status: Child ___ Single ___ Married___ Divorced___ Widowed___

Appt. confirmation by: (*check one)* - Cell/Text_____ E-Mail_____ Home Phone_____

Parent/Patient E-Mail address_____

Patient Employer/School _____ Patient Occupation_____

****

Emergency Contact (NOT a previously listed phone number)

Name_____Phone_____ Relationship_____

****

____ *ALTERNATE BILLING* **OR** ____ *OTHER PARENT INFORMATION*

Name_____ SS#_____ Birthdate_____

Address_____City_____State_____Zip_____

Home Phone_____ Cell_____ Work_____

****

PRIMARY ***DENTAL*** INSURANCE

Policy Holder Name: _____

Address_____

City_____ State ____ ZIP_____

Phone_____ DOB_____

Employer Name: _____

Dental Ins Company: _____

Policy Holder ID#_____SS#_____

Group #_____

SECONDARY ***DENTAL*** INSURANCE

Policy Holder Name:_____

Address_____

City_____State ____ ZIP_____

Phone_____ DOB_____

Employer Name:_____

Dental Ins Company: _____

Policy Holder ID#_____ SS#_____

Group# _____

****

Financial Responsibility Agreement, Assignment of Benefits Authorization & Cancellation Policy:

I hereby authorize the use of my signature on all insurance claim forms utilized by Franklin Street Dentistry for payment directly to Franklin Street Dentistry for services rendered to me/patient. I authorize this office to make and send copies of medical records as necessary to file my insurance claims. I understand that the account holder is responsible for charges incurred regardless of whether insurance pays or not. Past due accounts are subject to service charges (1.5% APR). I understand that if any unpaid balance is assigned to a third party collection agency or placed with an attorney to obtain judgment or otherwise satisfy payment of my account, a collection fee of up to 100% of the account balance will be added to my account. I agree to pay that fee. I also agree to pay attorney fees and court costs. Appointments cancelled with notice less than 24 business hours will be subject to up to a $50 cancellation fee. Repeated cancelled/failed appointments will risk patient dismissal from the practice.

By signing below, I confirm that I understand and agree to the above terms.

SIGNATURE_____ DATE_____