

**PATIENT REGISTRATION**

Patient  
First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Patient Is:  Policy Holder Preferred Name: \_\_\_\_\_  
 Responsible Party

Responsible Party (if someone other than the patient)

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_  
Address: \_\_\_\_\_ E-mail Address: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_ Pager: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Ext: \_\_\_\_\_ Cellular: \_\_\_\_\_  
Birth Date: \_\_\_\_\_ Soc Sec: \_\_\_\_\_ Drivers Lic: \_\_\_\_\_

Responsible Party is also a Policy Holder for Patient     Primary Insurance Policy Holder     Secondary Insurance Policy Holder

Patient Information

Address: \_\_\_\_\_ E-mail Address: \_\_\_\_\_  
City: \_\_\_\_\_ State/Zip: \_\_\_\_\_ Pager: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Ext: \_\_\_\_\_ Cellular: \_\_\_\_\_  
Sex:  Male  Female    Marital Status:  Married  Single  Divorced  Separated  Widowed  
Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Soc Sec: \_\_\_\_\_ Drivers Lic: \_\_\_\_\_  
E-mail: \_\_\_\_\_  I would like to receive correspondences via e-mail.

Responsible Party's Spouses Name: _____ Address: _____ City, State, Zip: _____ Home Phone: _____ Work Phone: _____	Emergency Contact: (NOT LIVING IN SAME HOUSEHOLD) _____ Phone: _____ Relationship To Patient: _____ Cell Phone: _____
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Primary Insurance Information

Name of Insured: \_\_\_\_\_ Patient's Relationship to Insured:  Self  Spouse  Child  Other  
Insured Soc. Sec: \_\_\_\_\_ Insured Birth Date: \_\_\_\_\_

Employer: _____ Address: _____ Address 2: _____ City, State, Zip: _____ Annual Benefits: _____ .00    Deduct: _____ .00    Grp# _____	Ins. Company: _____ Address: _____ City, State, Zip: _____ Claim Payor ID#: _____ Member ID# _____
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Secondary Insurance Information

Name of Insured: \_\_\_\_\_ Patient's Relationship to Insured:  Self  Spouse  Child  Other  
Insured Soc. Sec: \_\_\_\_\_ Insured Birth Date: \_\_\_\_\_

Employer: _____ Address: _____ Address 2: _____ City, State, Zip: _____ Annual Benefits: _____ .00    Deduct: _____ .00    Grp# _____	Ins. Company: _____ Address: _____ City, State, Zip: _____ Claim Payor ID#: _____ Member ID# _____
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How did you choose Dental Professionals? \_\_\_\_\_

If by referral, who can we thank? \_\_\_\_\_

### SIGNATURE ON FILE

I authorize the release of any information necessary to hospitals, doctors office, dental office, and/or to file claims for insurance benefits. This signature allows Dental Professionals to send information without my signature on each individual form.

I assign directly to Dr. Thomas Albiero, Dr. Keith Templin, Dr. Cynthia Jakusz and Dr. Chad Zambon, all dental insurance benefits paid for services rendered. I understand that I am financially responsible for all fees incurred.

\_\_\_\_\_  
(Authorized Signature of Covered Person)

\_\_\_\_\_  
Date

### MINOR CHILD TREATMENT RELEASE

I give permission to Dr. Thomas Albiero, Dr. Keith Templin, Dr. Cynthia Jakusz and Dr. Chad Zambon, and/or their designated assistant to perform any and all dental techniques and procedures including the administration of dental anesthetics on my minor child(ren), whether or not I am present at the actual appointment when the treatment is rendered.

\_\_\_\_\_  
Signed

\_\_\_\_\_  
Date

### FINANCIAL POLICY

The best dental care can only be maintained through complete understanding of both the dental care required, and the financial arrangements for that care. Our dental office personnel have been trained to assist you with any questions that may arise in these areas.

**Methods of payment:** Payment will be discussed at each visit. The options we offer are:

1. Payment at time of services.

We offer a 5% discount on cash payments or 3% on a credit card payment. Account balance must be cleared entirely at time of visit to qualify for these discounts.

2. Payment of estimated portion of fee not covered by insurance.

3. We accept *MasterCard* or *Visa* payments.

4. We also offer several commercial financial options so that you may have the dental treatment you need.

#### Dental Insurance:

Insurance may cover most or some of your charges. As a service to you, we will submit claims to your insurance company for you but you are ultimately responsible for the entire bill. Since insurance may not cover the entire cost of your service, you are asked to make regular payments. Our staff will be happy to assist you in calculating this estimated amount. Should there be an overpayment in the final analysis; the refund will be made directly to you. It is necessary that you provide us with accurate insurance information. You may also be asked in some cases to check with your insurance company on coverage or a payment irregularity. In addition, you will be asked to sign a form allowing us to collect directly from your insurance company and to release diagnostic information to them as may be necessary.

#### Accounts:

We do not become involved in domestic matters. The parent accompanying any minor will ultimately be held responsible for the account. We will send one bill for services and do not divide account balances in halves. We will help track who makes personal payment to the best of our ability and send reports upon request.

#### Late Payment Charges:

A service charge of 1.5% per month will be added to all accounts 90 days or older.

Should you have any questions about your statement, please call the office, we will make every effort to answer questions and resolve any problems.

If there is a need to reschedule an appointment, this should be done at least 24 hours prior to the appointment time if at all possible.

**APPOINTMENTS MISSED OR CANCELLED AT THE LAST MINUTE WILL BE BILLED TO YOU AT \$30.** (Insurance will not cover missed appointments).

Agreement Signature \_\_\_\_\_ Date \_\_\_\_\_