Patient Registration

(Please Print)

YOUR PAYMENT or CO-PAY IS DUE AT YOUR VISIT

Date:	Home Phone:	Cell Phone:	Work Phone:
Full Name:		Preferred Name:	SSN:

Street Address:	Email:
City, State & Zip:	

DOB:	Age:	Male or Female (Circle One)		Marital Status: Single____ Married_____ Divorced______ Widowed_____

Patient Employed by:_______________________________ Address:______________________________________

Occupation:_________________________________ Phone:____

(Circle One) Spouse / Significant Other: Or Parent	Date of Birth:	SSN:

Employed by: _______________________________ Address:_______________________________________

Occupation:_________________________________ Phone:____

Name of Dental Insurance Carrier:_____________________________________ Phone:___________________________________
Name of Insured:_____________________________________ SSN of Insured:_____-______-_______ DOB of Insured:_________
Insured's place of employment:________________________________ Do you have secondary Insurance? _______ Please list info:_______

Emergency Contact Information:_______________________________________ Phone: ___________________________________

How do you plan to pay for your treatment or co-pay? ____Cash _____Check _______Credit Card _____Finance Plan

If you have dental insurance, your estimated portion is due at the time of service.

Regardless of outstanding insurance your full account balance must be paid within 90 days of treatment.

Financial Agreement:

I acknowledge that payment is due at the time of treatment unless other arrangements are made prior to treatment. I agree that parents/guardians are responsible for all fees and services rendered for treatment of a minor/child. I accept FULL RESPONSIBILITY for all charges not covered by insurance, and agree that if my insurance has not paid within 90 days of treatment, the entire balance is immediately due. I understand that if I default on the terms outlined above, and my debt goes to a collection status, I agree to pay collection costs and/or reasonable attorney fees.

Signature:_______________________________________ Date:___________________

Assignment & Release:

I, the undersigned, have dental insurance with _________________________, and assign directly to METRO DENTAL GROUP all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance. I hearby authorize the office to release all information necessary to secure payment of benefits. I authorize this signature on all my insurance submissions whether manual or electronic.

Signature: ______________________________________ Date: ________________

Minor/Child Consent

I, being the parent/guardian of _________________________ do hearby request and authorize the dental staff to perform necessary dental services for my child, including, but not limited to X-rays, and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered.

Signature:_______________________________________ Date:____________________

PLEASE SEE REVERSE SIDE FOR MEDICAL HISTORY INFORMATION

Form updated 3/12/12

Medical History

Physicians Name:________________________________ Date of last Physical:_________ Phone:_________________________

Have you ever had? (Please check those that apply)

__ Heart Murmur	__ Epilepsy	__ Special Diet	___ Artificial joints/joint replacements
__ High Blood Pressure	__ Headaches	__ Swollen Neck Glands	___ Pacemaker
__ Low Blood Pressure	__ Hepatitis, Jaundice or Liver disease	__ Allergies to Anesthetics	___Bisphosphonate drugs
__ Rheumatic Fever	__ Circulatory Problems	__ Stroke	___ Smoker (If so how often?)_____
__ Cancer	__ Sinus Problems	__ Ulcer	___ Previous gum disease?
__ Nervous Problems	__ Psychiatric Care	__ Aids/HIV	___ Any Addiction? _____________
__ Radiation Treatment	__ Mitral Valve Prolapse	__ Venereal Disease	
__ Thyroid Disease	__ Artificial Heart Valves	__ Chemical Dependency	
__ Recent Weight Loss	__ General Allergies	__ Hemophilia	
__ Diabetes	__ Blood Disease	__ Arthritis	
__ Respiratory Disease	__ Other ______________________	__ Latex	

Do you have any drug allergies or have you ever had an adverse reaction to any medication or latex? ___________ If so, please explain: __
____

Are you taking or have you EVER taken a Bisphosphonate for any illness such as osteoporosis or cancer treatment? ______________

Have you ever responded adversely to medical or dental treatment?______________

Are you taking any medications at this time? ________ If so, please list:____

Are you under the care of a physician?____________ For what conditions?____

If patient is a child, what is his/her weight?_____________

(Women) Do you suspect you are pregnant? _______________ Approximate due date:________ Are you nursing?____________

Is there anything else we should know about your medical history or condition?____

Who may we thank for referring you? _______________________ or __ phone book __News paper __Other (Please list)
____

Your insurance coverage is based on a contract between you and the insurance provider. We deal with a great number of insurance plans and due to the many restrictions and limitations placed on each patient by their insurance company, it is impossible for our office to keep track of every patients' insurance requirements and restrictions. It is your responsibility to be aware of these.
As a courtesy we will file all dental insurance claims for you, this does not release you from your financial obligation. It is always best to check with the insurance company before seeking dental care. If your insurance has a co-payment, you are required to pay the co-payment at the time of your treatment. This is a requirement that is stated in your insurance contract. This does not guarantee that your insurance plan will pay your claim. You will still be responsible for the balance. If your claim is not paid, and you feel that it should have been, please contact your insurance company directly. They should be able to explain the reason to you.

All balances are due within 90 days, even if your insurance carrier delays or refuses payment.

HIPAA – Patient Privacy Acknowledgement

I ________________________ have received or viewed a copy of privacy practices.

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing, processing of insurance benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form. I understand that I am responsible for providing accurate dental insurance information for each visit.

____ __________________________

Form updated 3/12/12

Signature Date

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