**Dr. Amir P. Shaibani**
**Middlefield Family Dental**
**15561 West High St., Suite #20**
**Middlefield, Ohio 44062**
**Ph(440) 632-0389 Fax(440) 632-9669**

# PATIENT REGISTRATION

**Date:____________Patient Name:___________________________________Birthdate:_____________**

**Address:______________________________City:______________ State:____ Zip Code:___________**

**Home Phone:______________Work Phone:_______________Cellular:__________________________**

**MALE OR FEMALE AGE:______ MARITAL STATUS:_____________________________**

**Employment Status: Part Time, Full Time, Retired Patient Social Security #_________________**

**Student Status: Full Time Part Time School Name:___________________________________**

## RESPONSIBLE PARTY INFORMATION

***If patient and responsible party are the same – please proceed to Insurance Info.***

**Name:________________________________________________Birthdate:_______________________**

**Address:________________________________City:_______________State:____Zip Code:________**

**Home Phone:_______________Work Phone:______________Ext:____ Cellular:_________________**

**Relationship To Patient:_________________Social Security #of Responsible Party________________**

**Employer Name:______________________________Address:__________________________________**

**City:______________________State:________ Zip Code:_______Phone:________________________**

## DENTAL INSURANCE INFORMATION

**Name of Dental Insurance Co.:___________________________________________________________**

**Insurance Co. Address: _________________________________________________________________**

**City:_____________________________________________________ State:__________ Zip_________**

**Phone Number:_________________Member ID#________________Group #:____________________**

**Policy Holder Name:_________________________________________Birthdate:__________________**

**Social Security # of Policy Holder:_____________________Relationship To Patient:_______________**

**Employer Name:______________________________Address:__________________________________**

**City:______________________State:________ Zip Code:_______Phone Number:_________________**

**Do you have Secondary Dental Insurance? Y or N (circle please)**

## MIDDLEFIELD FAMILY DENTAL FINANCIAL POLICY

Thank you for choosing our office for your professional dental care. We are committed to your successful treatment. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy, which we require you to read and sign prior to any dental treatment.

**FINANCIAL RESPONSIBILITY:**

- The name listed in the "Responsible Party Information" is responsible for all fees incurred.
- Payment in full is due on the day of treatment.
- If we are filing an insurance claim for you, we ask that your co-payment be made on the day of treatment. We accept cash, check, Master Card, Visa, Discover, and Debit Card. Please bring your office co-pay at the time of service. You should also be aware that according to your insurance policy, additional co-payments and or deductibles might be incurred. Our office will bill for these amounts as this information comes from insurance after they have received and processed your claim for service and you will be required to submit payment immediately. All registration and insurance information must be supplied to our office at the time of service; otherwise our office will not be responsible for submission of any insurance claims on your behalf. Should any issue with insurance non-payment arise due to failure to provide the information requested above, the patient and or responsible party would remain accountable for full payment of service. Insurance claims are submitted as a courtesy to our patients. We reserve the right to not process certain claims. Please be aware that if you are an established patient with our office that you must provide us with your current information i.e. address, phone, insurance, place of employment, date of birth etc., of the insured. You may also be requested to complete yearly-signed registration form in your chart to submit to your insurance.
- **Multiple Payments:** For treatment requiring multiple appointments (Dentures, Partials, Appliances, etc.) 50% of the total charge is due at the beginning of treatment. Additional payments may be required at each appointment.

**CUSTODY AND FINANCIAL RESPONSIBILITY**

Our office will consider the parent who brings the child for an appointment financially responsible for payment, regardless of any documents or handwritten notes stating that they will NOT accept responsibility. Our office will not see any child under the age of 18 without parental/legal guardian consent. It is not the responsibility of Middlefield Family Dental to enforce parents' court orders regarding responsibility.

## DENTAL INSURANCE ASSIGNMENT AND RELEASE

***I, the undersigned certify that I (or my dependent) have insurance coverage and assign directly to Dr. Shaibani – Middlefield Family Dental all insurance 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. Please Note: Any outstanding balances not paid with in 30 days after billing date will be charged 32% collection fee & legal recovery fee along with interest at 1 ½% per month. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.***

**Responsible Party Signature: ______________________________ Date: __________**
**Relationship to Patient: ____________________________**

## PATIENTS WITHOUT DENTAL INSURANCE

***I understand that I am financially responsible for all charges incurred. Please Note: Any outstanding balance not paid with in 30 days after billing date will be charged 32% collection fee & legal recovery fee along with interest at 1 ½% per month.***

**Responsible Party Signature: ______________________________Date: ___________**
**Relationship to Patient: ________________________________**