PATIENT REGISTRATION - *Confidential*

Charles R. Fields DMD, PC

vers. 02/11

Date _____

Name: ◊ Dr. ◊ Mr. ◊ Mrs. ◊ Miss ◊ Ms. _____ (first / init. / last)

Address: _____ (street / apt# if any / city / state / zip)

Date of Birth: (month /day / year) _____ **Your Social Security Number**: _____--____--_____

Home Phone: ( )_____ **Email** _____

Work Phone: ( )_____ ext _____

Employer: _____ **Occupation**:_____

Spouse's / Parent's / Guardian's Name: _____

Spouse's / Parent's / Guardian's contact Phone Number: ( )_____

Emergency contact name and number: _____( )_____

*** OFFICE PAYMENT POLICY ***

To control overall costs, we ask that payment be made in advance or as services are rendered. Fees are based on difficulty and time; estimated costs may increase due to unforeseen complexity. Fees are not refundable; a credit will apply instead until all treatment is complete. A charge may be applied for late notice/broken appointments. Sedation appointments and cases involving large treatment plans require a payment arrangement **prior** to treatment. We subscribe to a limited number of insurance plans. Routine insurance submissions are performed as a courtesy to you. However, an administrative fee will apply for complicated / excessive insurance processing.. We do not submit medical insurance claims. **We do require proof of insurance (e.g. a card) in order to develop and process any insurance claim.**

Insurance info*: Subscriber Name:* *Subscriber Date of Birth:*
Subscriber SS#:

The patient is ultimately responsible for the cost of services, not the insurance company. All costs (e.g. collections agency, court costs/legal fees, returned check fees, certified letter costs) related to payment on delinquent account balances are the patient's responsibility. Fees are charged for insufficient funds on your bank or credit card accounts. There is a minimum finance charge of 5% of the amount due and interest 2% per month on unpaid balances over 60 days.

I comprehend English and know that I am ultimately responsible for all costs and agree to the office policies as outlined above,

Signature _____

OFFICE PRIVACY POLICY

Our office always attempts to protect the privacy of our patients. We do comply with all federal (HIPAA), state and local regulations regarding this issue. A copy of our privacy policy is available on request and is posted in the waiting room for public viewing. Information regarding your care is only shared as a professional necessity; no information is shared for any other reason.

I comprehend English and acknowledge that I have seen and/or received a copy of the office's privacy policy.

_____
initials