Patient Registration

Parkcrest
DENTAL GROUP

Patient Name				
Nickname	Sex: ❑ M ❑ F	Birthdate	Age	Today's Date
Home Address		City	State	Zip
Please Check One: ❑ Single ❑ Married ❑ Separated ❑ Widow	Occupation			
Email Address	Cell Phone Number			Home Phone Number
Patient Employer	How Long Employed	Patient Soc Sec. #		Work Phone
Are you a full time student? ❑Yes ❑ No	Grade/school			
Name of spouse		Spouse's Date of Birth		Cell Phone
Spouse's Employer	Spouse's Soc. Sec. #			Work Phone
Person responsible for account		Responsible party social security number		

How did you hear about our office?	**EMERGENCY INFORMATION** Name, Address, & telephone of a relative **not** living with you.
Reason for this visit	
Who may we thank for referring you to our office?	

If Patient is a Minor

Mother's Name	Father's Name
Mother's Address	Father's Address
Mother's DOB	Father's DOB
Mother's Home #	Father's Home #
Mother's Cell #	Father's Cell #
Mother's Work #	Father's Work #
Mother's Employer	Father's Employer

Financial Guidelines

Parkcrest
DENTAL GROUP

Thank you for choosing Parkcrest Dental Group as your dental health care provider. We are committed to providing you with the highest quality lifetime dental care, so that you may fully attain optimum oral health. Please understand that payment of your bill is considered part of your treatment.

Payment is due at the time service is provided. Our office accepts cash, personal checks, MasterCard, Visa, and Discover. Outside financing is available upon request and approval.

❑ **Please check if you would like more information about financing options.**

Please Note: Returned checks will be subject to additional fees. In the case it becomes necessary for our office to enlist a collection service and/or legal assistance; you will be responsible for any collection and/or legal charges incurred.

Do You Have Insurance?

- As a courtesy to you we will help you process all your insurance claims. Please understand that we will provide an insurance estimate to you, however it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits ultimately determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible.
- All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company. Our office is not a party to that contract.
- Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of rates.
- We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office.
- We ask that you pay the deductible and co-payment, which is the estimated amount not covered by your insurance company, by cash, check, MasterCard, Visa or Discover at the time we provide the service to you.
- Insurance payments are ordinarily received within 30-60 days from the time of filing. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.
- We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.

We thank you for the opportunity to serve your dental health care needs and welcome any questions you may have concerning your care or our financial policy.

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO PARKCREST DENTAL GROUP.

Signature _____ Date _____
(Patient or Guardian)