



PATIENT REGISTRATION

Date: _____

Patient Name (Last, First, Middle Initial):			Home Phone:	Work Phone:	Cell Phone:
Present Address:			City:	State:	Zip:
Age:	Birthdate:	E-mail Address:	If Patient is a Minor, Parent/Guardian Name:		Spouse's Name:
Previous Address (if less than 3 yrs.):			City:	State:	Zip:
Patient's Employer:			Employer's Address:		
Whom May We Thank for Referring You to Our Office?					

DENTAL INSURANCE INFORMATION

Name of Insured (Last, First, Middle Initial):			Insured's SS #:	Insured's Birthdate:	
Name of Insured's Employer:					
Address of Insured's Employer:			City:	State:	Zip:
Name of Insurance Company:				Insurance Company Phone #:	
Address of Insurance Company:			City:	State:	Zip:
Group Number:			Employee I.D. Number:		

IS PATIENT COVERED BY ANOTHER DENTAL PLAN? IF YES, COMPLETE THE FOLLOWING:

Name of Insured (Last, First, Middle Initial):			Insured's SS #:	Insured's Birthdate:	
Name of Insured's Employer:					
Address of Insured's Employer:			City:	State:	Zip:
Name of Insurance Company:				Insurance Company Phone #:	
Address of Insurance Company:			City:	State:	Zip:
Group Number:			Employee I.D. Number:		

X

Signature (Parent's Signature if Minor)

Fees and Payment Policy

Our office offers the following financial policy so that our patients can comfortably afford dental care:

1. We accept payment by cash, check or credit card (Visa, MasterCard, Discover, American Express). If you pay at the start of appointment sequence or time treatment is rendered, take a **5% rebate**. (Any prior outstanding balance must be fully paid). Prepayment saves us time and the expense of billing, enabling us to provide this valuable service. If you have dental insurance, we will offer this discount for the portion of the fee that is not covered by insurance. (co-payment or deductible)

A **Senior discount of 10%** is offered to our patients 65 years and older for payment by cash, check, or credit card at the start of appointment sequence or time treatment is rendered. (Any prior outstanding balance must be fully paid).

2. All fees for service are due at the time of the appointment. However, if we accept assignment of benefits from your insurance company, payment will be received directly by our office and any co-payments and deductibles will be billed to you. (*Interest will accrue at 12% A.P.R. 60 days after completion date*). You may also preauthorize us to automatically charge your co-payments to a credit card to take a **2% rebate**.
3. If you prefer to pay out larger portions of treatment on your credit card or checking account on a regular monthly basis, we can accommodate you by having you sign a monthly authorization card. Once per month your card or account will be charged the allotted monthly amount. This can spread out payments for up to six months. (minimum \$50/month)
4. Outside financing options are available for all treatment via *Care Credit Payment Plans*. **Interest free financing** is available if qualified for **up to 12 months**. Inquire about details.

Insurance

If you have dental insurance, we will help you determine the coverage you have available. All insurance forms will be processed by our office as a courtesy to our patients at no charge. We ask only that you assign your insurance benefits to our office.

We must **emphasize** that as dental care providers, our relationship is with **you**, the patient -- not the insurance company. If we do not receive payment from your insurance carrier within 60 days, **payment becomes the responsibility of the patient**. Due to the endless variations and limitations of insurance plans, the patient is liable for any balance that remains after insurance payments. The balance not covered by insurance will be arranged for you to pay as listed above.

Blue Cross Dental, United Concordia, Delta Dental, and MetLife Insurance:

As a participating office, we are bound in most instances to accept these insurance companies' prevailing payments as reimbursement in full. We will bill the patient for any deductible or co-insurance as obligated by the policy.

Cancellation Policy

Kindly give us 48 hours' notice if it ever becomes necessary for you to change a scheduled appointment. Two consecutive "missed" appointments without prior notice may result in a required \$50 refundable deposit before additional treatment time can be scheduled.

Financial Authorization

- Accounts outstanding more than 60 days from treatment date will incur a FINANCE CHARGE of 1% per month or 12% per year.
- I hereby authorize payment directly to Trexler Family Dental Care insurance benefits otherwise payable to me.
- I understand that I am responsible for all costs of dental treatment.

Signature _____ Date _____