PATIENT REGISTRATION FOR GARY R. ACKERMAN D.D.S.

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

RESPONSIBLE PARTY INFORMATION

DATE

NAME

ADDRESS

CITY STATE ZIP

HOME PHONE NO.

CELL PHONE NO.

WORK PHONE NO.

EMPLOYER

BUSINESS ADDRESS

OCCUPATION/POSITION

SOCIAL SECURITY NO.

DRIVER LICENSE NO.

BIRTHDATE AGE MALE FEMALE

MARRIED SINGLE DIVORCED WIDOWED

PATIENT INFORMATION - IF DIFFERENT THAN ABOVE

NAME

ADDRESS

CITY STATE ZIP

HOME PHONE NO.

SOCIAL SECURITY NO.

DRIVER LICENSE NO.

BIRTHDATE AGE MALE FEMALE

MARRIED SINGLE DIVORCED WIDOWED

PATIENT'S SPOUSE OR OTHER PARENT

NAME

WORK PHONE

EMPLOYER

BUSINESS ADDRESS

OCCUPATION/POSITION

CELL PHONE NO.

SOCIAL SECURITY NO.

DATE OF BIRTH

DRIVER LICENSE NO.

EMPLOYER

BUSINESS ADDRESS

OCCUPATION/POSITION

DENTAL INSURANCE

PRIMARY CARRIER

NAME OF INSURED

NAME OF INSURANCE

ADDRESS OF INSURANCE

CITY STATE ZIP

PHONE NO. OF INSURANCE

GROUP NO.

SECONDARY INSURANCE INFORMATION

NAME OF INSURED

NAME OF INSURANCE

ADDRESS OF INSURANCE

CITY STATE ZIP

PHONE NO. OF INSURANCE

GROUP NO.

ADMINISTRATION NOTES

GETTING TO KNOW YOU

HOW DID YOU HEAR ABOUT US?

ARE ANY OF YOUR OTHER FAMILY MEMBERS PATIENTS OF OURS?

NAME RELATIONSHIP

NAME RELATIONSHIP

NAME RELATIONSHIP

NAME RELATIONSHIP

IN CASE OF AN EMERGENCY

WHO CAN WE CONTACT?

ADDRESS

CITY STATE ZIP

PHONE NO.

Financial Policy

Please read and initial each item. Feel free to ask any questions or discuss concerns with us. After you have read and understand each item, please sign in the designated area.

______I understand and agree that all fees incurred are due at the time of service, unless arrangements are mutually agreed upon prior to the onset of treatment.

______I understand and agree that I will be charged a $30.00 service fee for all returned checks.

______I understand and agree that all balances over 60 days are subject to a 1.8% finance charge. The only way to avoid this charge is to pay in full at the time of service.

______I understand and agree that if my balance goes over 90 days past the day of treatment I must pay it immediately or risk being sent to collections.

Insurance Policy

Please read and initial each item even if you do not currently have insurance. Otherwise, you will be required to file your own claims in the event you obtain insurance.

______I understand and agree that I am responsible for all fees incurred regardless of insurance coverage.

______I understand and agree that this office will bill my insurance as a courtesy, but in no way assumes responsibility for any fees owed.

______I understand and agree that all estimated cc-pays are due at the time of service. In the event the insurance pays less than the estimated cc-pay, I agree to pay it immediately.

______I understand and agree that this office will bill my insurance as a courtesy, and that I am ultimately responsible for all charges incurred in this office.

______I understand and agree to provide all necessary information to bill the insurance initially and in the event insurance changes or terminates.

______I understand and agree that if the insurance pays later than 90 days, I will pay the balance in full immediately.

______I understand and agree that I am responsible for providing all necessary information to bill the insurance.

Consent for Treatment

______I hearby authorize doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor to make a through diagnosis of the patients dental needs.

______Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

______I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

______Lastly I understand and agree that by initialling each item above and by signing below I am fully aware of my obligation and agreement to the policies listed above as well as give my consent for treatment.

Patient or Responsible Party ______________________________ Date______________

Relationship to Patient ____