PATIENT REGISTRATION

Patient's Name: ________________________ Birthdate: __________ Social Security #: _______________
Home Address: ____ Apt/Unit #: _________
City: __________________________ State: _____ Zip: __________ Cell Phone: ____________________
Home Phone: ___________________ Email Address: _____________________________________
Nickname: ______________ Please Circle: Single – Married - Separated – Divorced Gender: M – F
Your Employer: ____________________ Occupation: _________________ How Long Employed: _______
Spouse's Name: ____________________ Spouse's Occupation: _______________ Work #: ____________
Emergency Contact: ____________________ Relationship: _____________ Phone #:_________________
How did you hear about our office? ________________ Choose your type of reminders: Text – Email – Phone

Responsible Party (if different than patient): ___________________________________ DOB: __________
Relationship: ______________ Social Security #: _______________ Cell Phone: _____________________

MEDICAL INSURANCE

Subscriber's Name: ___________________________ DOB: _________ Relationship to patient: _________
Subscriber's SSN: _____________________ Insurance Company: ___________________________________
Policy #: ________________________________ Group #: ______________________________________

SUPPLEMENTAL DENTAL INSURANCE

Insured Name: _____________________________ DOB: ___________ Relationship to patient: _________
Insured SSN: _________________________ Employer: ____
Insurance Company: ______________________________________ Group #: ______________________

ADDITIONAL SUPPLEMENTAL DENTAL INSURANCE

Insured Name: _____________________________ DOB: ___________ Relationship to patient: _________
Insured SSN: _________________________ Employer: ____
Insurance Company: ______________________________________ Group #: ______________________

FINANCIAL POLICY

Thank you for choosing our office as your dental health care provider. We are committed to providing you with the highest quality dental care, so that you may fully attain optimal oral health. Please understand that payment of your bill is considered part of your treatment and payment is due at the time service is provided. Financing is available upon request and approval. Returned checks will be subject to an additional fee of $100 and is against Nevada State Law. 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.

Please take note:

- We will help you process all your insurance claims as a courtesy to you. Understand that we will provide an insurance estimate to you, however, it is not a guarantee that your insurance will pay exactly as estimated. Insurance companies are full of tricks and policies designed to save their profits and not help you. Your insurance company and your plan benefits ultimately determine the cost of treatment. 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. By the same token, your insurance company isn't concerned with your oral or overall health.

  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 our fees are equivalent to what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary 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.
- 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, legal or otherwise, 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 MEDICAL AND/OR DENTAL INSURANCE COMPANY TO PAY MY MEDICAL/ DENTAL BENEFITS DIRECTLY TO MY DENTAL OFFICE.

CONSENT

The undersigned hereby authorizes Smiles for Life Family Dentistry and it's providers to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of the patient's dental needs. I also authorize and give my informed consent to Smiles for Life Family Dentistry and it's providers to perform any and all forms of treatment, medication and therapy that may be indicated in my best interest. I understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for all services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a finance, rebilling, collection charge or attorney fee will be added to any overdue balance.

Patient Signature (or parent): ____ Date: ______________