ANTHONY
DENTAL CARE

PATIENT REGISTRATION

First Name: _____ Last Name: _____Middle Initial: ____
Preferred Name:_____ Patient Is: ( ) POLICY HOLDER ( ) RESPONSIBLE PARTY

Responsible Party (if someone other than the patient)
First Name:_____ Last Name: _____ Middle Initial: ____
Address: _____ City, State, Zip: _____
Home Phone: _____ Cellular: _____
Birth Date: _____ Social Security Number: _____

Patient Information
Address: _____ CIty, State, Zip: _____
Home Phone: _____ Cellular: _____
Sex: ( ) Male ( ) Female Marital Satus: ( ) Married ( ) Single ( ) Divorced ( ) Separated ( ) Widowed
Birth Date: _____ Social Security Number: _____
Email: _____ ( ) I would like to receive correspondence via email

Emergency Contact
Name: _____ Relationship: _____ Phone Number: _____
Name: _____ Relationship: _____ Phone Number: _____

( ) I AM SELF PAY ( ) I HAVE DENTAL INSURANCE

DENTAL INSURANCE INFORMATION

Primary Insurance Information *PLEASE PRESENT CARD TO OFFICE STAFF*
Name of Insured: _____ Relationship to insured: ( ) Self ( ) Spouse ( ) Child
Insured SSN or Member ID: _____ Insured DOB: _____
Employer: _____ Insurance Company: _____
Group #: _____ Customer Service Phone Number: _____
Claims Mailing Address: _____

Secondary Insurance Information *PLEASE PRESENT CARD TO OFFICE STAFF*
Name of Insured: _____ Relationship to insured: ( ) Self ( ) Spouse ( ) Child
Insured SSN or Member ID: _____ Insured DOB: _____
Employer: _____ Insurance Company: _____
Group #: _____ Customer Service Phone Number: _____
Claims Mailing Address: _____

How did you hear about us? _____

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CONSENT FOR USE AND DISCLOSURE

First Name: _____ Last Name: _____ Middle Initial: _____
Preferred Name: _____ Date of Birth: _____

Please read the following statement carefully.

Purpose of Consent: By signing this form, you will consent to use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Right to Revoke: You will have the right to revoke the Consent at any time by giving us written notice of your revocation submitted to the Consent Person listed on Your Privacy Notice. Please understand that revocation of this Consent will not affect any action we took in reliance to this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

To Whom may we speak to about personal dental records and/or personal financial record concerns for this patient. (ex: spouse, grandparent, friend, caregiver, etc..)

AUTHORIZATION

Name: _____ Relationship: _____ Phone Number: _____
Name: _____ Relationship: _____ Phone Number: _____
Name: _____ Relationship: _____ Phone Number: _____

( ) By checking this box, I understand the above Notice of Privacy Practices and may request a copy of the Notice of Privacy Practices from Anthony Dental Care, LLC at any time.

Relationship to Patient: ( ) Self ( ) Parent ( ) Guarantor ( ) Other

Signature: _____

LATE AND MISSED APPOINTMENT POLICY

We strive to render excellent dental care to you and the rest of our patients. In an attempt to be consistent with this, we have a Late and Missed Appointment Policy. When an appointment is scheduled, that time has been set aside specifically for you. When it is missed, that time cannot be used to treat another patient.

Our Policy is as follows:
We require that you give our office a 24 hour notice in the event that you need to reschedule your appointment. This courtesy allows us minimum time to try and schedule another patient who requires our time for their treatment needs. If you miss an appointment without contacting our office within the required time, this is considered a missed appointment. A fee of $35.00 will be charged to you: this fee cannot be billed to your insurance company and will be your direct responsibility. No future appointments can be scheduled without the payment of this fee. Fee shall be waived only for unforeseen circumstances at Anthony Dental's discretion.

Late Arrival:
If you arrive more than 15 minutes late, your appointment may be rescheduled in order to meet the needs of those who are on time for their pre-reserved visit. If this happens it will be considered a missed appointment. If you have any questions regarding this policy, please let our office staff know and we will be glad to clarify any questions you have.

I have read and understand the Late and Missed Appointment Policy of Anthony Dental Care and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

Signature of Patient: _____ Date: _____

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AUTHORIZATION AND CONSENT FOR SERVICES

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I authorize the diagnosis of my dental health by means of radiographs or other aids deemed appropriate.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

The practice depends upon reimbursement from patients for the cost incurred in their care. Financial responsibility on the part of each patient should be determined before treatment.

Patients with dental insurance understand that all dental services are the financial responsibility of the patient. We will submit claims to dental insurance carriers as a courtesy to the patient. Any applicable copays are due on the date of services unless written payment arrangements have been made in advance. All estimates provided are estimates only.

A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 90 days, unless previously written financial arrangements are satisfied.

I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of the patient information.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment. I further agree that the charges for services shall be as billed unless objected to, by me, in writing within the time payment is due.

I grant permission to you or your assignee, to telephone me to discuss this statement or my treatment.

( ) By checking this box, I acknowledge that I have read the above conditions and agree with the contents.

Signature: _____ Date: _____