Patient Registration

Last Name _____ First Name _____ MI ___ Preferred Name _____

Date of Birth _____ Sex M or F Soc. Sec. #_____ Please Circle one: Single Married Separated Widow

Mailing address _____ City _____ State ____ Zip Code _____

Home Phone (____)_____ Cell Phone (____)_____ Email _____

Driver's License # _____ Employer _____ Work Phone (____)_____

If Patient is a minor

Name of Parent _____ Parent Soc. Sec. # _____ Parent Phone (____)_____

Person Responsible for Account _____ Relationship _____

Emergency Contact _____ Relationship _____ Phone (____)_____

How did you hear about us? _____ Reason for today's visit? _____

Dental Insurance Information (Primary Carrier)

Insured's Name _____

Insured's Employer _____

Insured's DOB _____

Insurance Co _____

ID # _____Group # _____

Dental Insurance Information (Secondary Carrier)

Insured's Name _____

Insured's Employer _____

Insured's DOB _____

Insurance Co _____

ID # _____Group # _____

FINANCIAL POLICY

The following is a statement of Rachel E. Johnson, D.M.D Family and Cosmetic Dentistry financial policy, which we require that you read, agree to, and sign prior to any treatment. Payment is due at the time service is provided.

- Returned checks will be subject to a $35 fee. In the case it becomes necessary for our office to enlist a collection service and/or legal assistant; you will be responsible for any collection and/or legal charges up to 40%.
- 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. We do not provide information about co-payments, secondary insurance, or deductibles. If there is an additional balance due after your insurance claim is filed, you will receive a bill from us.
- 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 will determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible. 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. If for any reason we do not receive the anticipated payment from your insurance company you are responsible.
- 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, credit card or Patient Financing at the time we provide the service to you.
- 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 are in network providers for Delta Dental, Cigna, BCBS and United Healthcare
- It is your responsibility to provide accurate insurance information to this office. If we are unable to bill your insurance carrier because we did not receive your insurance information in a timely manner, you are responsible for the charges.

Consent: I have read, understand and agree to the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to my dental office. I understand that responsibility for payment for Dental 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 and/or attorney fee will be added to any overdue balance. By signing below, you are authorizing us to call you at any number you provide including calls to mobile/cellular or similar devices for any lawful purpose. You agree to any fees or charges that you may incur for an incoming call from us, and/or outgoing calls to us, to or from any such number, without reimbursement from us.

_____ _____

Patient Signature (Parent if child) Date