# PATIENT REGISTRATION

TODAY'S DATE _____ Home Phone # _____

Patient _____

*Last name* *first name* *initial* *circle or add: (Mr, Ms, Mrs., Dr., Hon.)*

I prefer to be called _____ Male _____ Female _____

Birthdate _____ / _____ / _____ Age _____

Full Address _____ City _____ State _____ Zip Code _____

E-mail Address _____ CELL PHONE # _____

Married ____ Single ____ Divorced ____ Widowed ____ Separated ____

Employer Name & Address _____ Office Phone # _____

Position _____ Office Fax # _____

Whom may we thank for referring you? _____

General Dentist Name _____ Phone # _____

Other Family Members seen by us _____

Spouse's Name _____ Employer _____

Spouse's Daytime # _____ Occupation _____

Person Responsible for Account: (only if patient is a minor or disabled)

Name _____ Daytime # _____

Street/City/State/Zip _____

Employer/Address _____ Soc. Sec. # _____

Birthdate _____ Relationship to patient _____

I agree to be financially responsible for the above patient _____

Payment for services are due at the time of treatment. We do not offer financing. American Express, Visa, Mastercard, Discover, cash, checks, and Care Credit are accepted.

If unable to keep a reserved appointment we request notice of 2 business days (5 for surgical sessions) and reserve the right to charge a broken appointment fee up to $150.00 for repeated late cancellations or no show.

**Regarding Dental Insurance:** ***WE ARE OUT OF NETWORK WITH ALL CARRIERS***

We offer insurance billing assistance for treatment fees of $500.00 or more. You must provide current information and a signed consent/ authorization form to be kept on file. If you choose to reserve an appointment before your carrier's pretreatment estimate has processed, we require fees to be paid at the time of service. You as the patient assume financial responsibility for your care.

For services under $500.00 we provide an attending dentist statement for you to submit to your insurance carrier. If your insurance carrier has any requests for radiographs or records, we will need your signed consent on file in your chart.

Primary Carrier Name and Address: _____

Patient Relationship to employee: _____ Subscriber birthdate: _____ Subscriber sex: M F

Subscriber name and address: _____

Subscriber ID # _____ Policy # _____

Subscriber's Employer: _____

Are you covered by a Secondary Plan? Yes or NO If so:

Secondary Carrier Name and Address: _____

Patient Relationship to employee: _____ Subscriber birthdate: _____ Subscriber sex: M F

Subscriber name and address: _____

Subscriber ID # _____ Policy # _____

Subscriber's Employer: _____

I have been informed of the treatment plan and fees. I agree to be responsible for all fees for services and materials not paid by my dental benefit plan. To the extent permitted by law I consent to your use of my protected health information to carry out payment activities in connection with this:

_____ Date _____

I hereby authorize payment of the benefits otherwise payable to me directly to Buckhead Periodontics, P.C.

_____ Date _____