



# Putnam Family Dental

## Patient Registration Information

CONFIDENTIAL

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
                    First                                    Middle                                    Last

### WELCOME TO OUR PRACTICE!

Thank you for selecting our dental healthcare team. Please fill out this form completely in ink. If you have any questions or concerns, please do not hesitate to ask for assistance-we will be happy to help!

### Patient Information

Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Birthdate \_\_\_\_\_ SS# \_\_\_\_\_ Home Phone \_\_\_\_\_  
Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ E-Mail \_\_\_\_\_  
Do you prefer to receive calls at:      Work      Home      Cell      Either

Are you:     Minor     Single     Married     Divorced     Widowed     Seperated

You or your parent/guardian's employer \_\_\_\_\_ Occupation \_\_\_\_\_

Business Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Spouse or parent/guardian's name \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

If you are a student, name of school/college \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Person to contact in a case of an emergency? \_\_\_\_\_

### Responsible Party

Name of person responsible for this account \_\_\_\_\_ Relationship \_\_\_\_\_  
Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ SS # \_\_\_\_\_  
Driver's License # \_\_\_\_\_ Birthdate \_\_\_\_\_ Financial Institution \_\_\_\_\_  
Employer \_\_\_\_\_ Work Phone \_\_\_\_\_  
Is this person currently a patient in our office? Yes \_\_\_\_\_ No \_\_\_\_\_

### Dental Insurance Information

Name of Insured \_\_\_\_\_  
Relationship to patient \_\_\_\_\_ D/O/B \_\_\_\_\_ SS# \_\_\_\_\_ Date Employed \_\_\_\_\_  
Address of Employer \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Ins. Company Address \_\_\_\_\_  
Group# \_\_\_\_\_ ID# \_\_\_\_\_ How much is your deductible? \_\_\_\_\_  
How much have you used? \_\_\_\_\_ Annual Maximum Benefit \_\_\_\_\_  
Do you have additional Dental Insurance? \_\_\_\_\_



**ATTENTION PATIENTS**



**You Are Responsible For Knowing Your Dental Insurance Benefits**

Dental plans differ significantly. Each patient should know and understand his or her individual benefit package. Please contact your insurance company at the telephone number on your insurance card if you have questions regarding your coverage.

Patients with dental insurance are responsible for paying any co-payment, deductible, or fees for non-covered services at the time the services are rendered. We will be happy to give you an estimated treatment plan, however this is *only an estimate* and the patient is ultimately responsible for any payment not covered by insurance.

To help you get the most from your dental plan, we encourage you to become familiar with your insurance plan before seeking care.

X \_\_\_\_\_  
Signature of patient or parent/guardian if minor Date

**AUTHORIZATION, RELEASE & AGREEMENT TO PAY FOR SERVICES RENDERED**

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such Dental Care to third party payors and/or other health practitioners.

I authorize and hereby request insurance company to pay directly to the dentist (or the dental group) insurance benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependent(s).

X \_\_\_\_\_  
Signature of patient or parent/guardian if minor Date

**FINANCIAL ARRANGEMENTS**

For your convenience, we offer the following methods of payment. Please check the option in which you prefer. If you have any questions concerning financial arrangements or need special arrangements, please ask for assistance.

**Payment in full at each appointment**

\_\_\_\_ CASH \_\_\_\_ PERSONAL CHECK  
\_\_\_\_ CREDITCARD \_\_\_\_ VISA \_\_\_\_ MASTERCARD \_\_\_\_ CARE CREDIT

CARD# \_\_\_\_\_ EXPIRATION DATE \_\_\_\_\_

**REGARDING MISSED AND CANCELLED APPOINTMENTS**

At Putnam Family Dental, we strive to deliver our Best services at the most convenient times for our patients. It is for this reason we offer **LATE EVENING & WEEKEND** hours. This is why we will impose a **\$50 "MISSED APPOINTMENT" fee PER HOUR** on appointments not cancelled and/or rescheduled within a timely manner. We ask that you kindly provide us with at least a **24-HOUR NOTICE OF CANCELLATION.**

X \_\_\_\_\_  
Signature of patient or parent/guardian if minor Date