Patient Registration Date ________________________

Whom may we thank for referring you?

☐ Convenient Location ☐ Internet ☐ Yellow Pages ☐ Insurance ☐ Aurora Chamber ☐ Other/Mailing

☐ Friends/Family (Name) ______________________________ ☐ Staff Member (Name) _________________________

Patient Information

Name ____ Birth Date _________________________

Address ____

City ____ State ___________ Zip ___________________________

Home Phone (_____) ________________ Work (_____) _________________ Cell (_____) ________________

Email ____ ☐ I would like to receive correspondences via e-mail

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Social Security # ___________________________ Driver's License # ____________________________________

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired Student Status: ☐ Full Time ☐ Part Time

If Student, Name of School/College____

Responsible Party (if someone other than patient)

Name of Person Responsible for this Account ____

Address ____

City ____ State ___________ Zip ___________________________

Home Phone (_____) ________________ Work (_____) _________________ Cell (_____) ________________

Birth Date _______________________________ Social Security # ____

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Signature of Responsible Party ____

OVER PLEASE

Payment Agreement

Dental services rendered without previous dental insurance arrangements, or other previous financial arrangements must be paid for at the time services are rendered.

I understand that all dental services furnished are charged directly to me and that I am personally responsible for payment of all dental services. This office will help prepare the patients insurance forms and assist in making collections from insurance companies and will credit any such collections to the patient's account. When using insurance benefits I herby assign all insurance benefits to Meadow Lake Dental Care and authorize this office to supply any information required by my insurance company. I agree that estimated insurance benefits and estimated patient payments provided by the dental office are estimates only and I am responsible for all charges not paid by my insurance company within 60 days or a longer reasonable amount of time as determined by dental office. I understand that any resulting overpayments will be refunded to me. I agree to pay a service charge of 1 ½ % or 75 cents per month (whichever is greater) on the balance of my account exceeding 60 days unless previously written financial arrangements are satisfied. In consideration for the professional services rendered to me, or at my request, by Meadow Lake Dental Care, I agree to pay the reasonable value of said services to Meadow Lake Dental Care. I further agree that the reasonable of said services shall be as billed unless objected to by me at the time services are rendered. I also agree that if this account is placed with a third party for collection, I am responsible for all reasonable collection and /or attorney fees incurred by Meadow Lake Dental Care.

I agree to pay a $45 service fee for any appointment made by me that is not cancelled within 48 hours of the scheduled appointment time.

I grant my permission to you of our assignee, to telephone me at home or at my work to discuss matters related to this form. I further agree that a waiver of any breach of any time or condition here under shall not constitute a waiver of any further term or condition.

I have read the above conditions of treatment and payment and agree to this content.

Signature of Responsible Party____

Relationship to Patient _____________________________________ Date ___________________________