HERITAGE DENTAL

PATIENT REGISTRATION

Date _____

Patient Information

Patient's Name _____ r Male r Female

Preferred Name _____ Birthdate _____

Marital Status r Single r Married r Divorced r Widow

Address _____ Home Phone _____

City _____ State _____ Zip _____

Employer _____ Work Phone _____

City _____ State _____ Zip _____

E-mail Address _____ Cell Phone _____

Responsible Party Information

Parent / Spouse of above _____

Address _____ Phone _____

City _____ State _____ Zip _____

Employer _____ Work Phone _____

Address _____ State _____ Zip _____

Cell Phone _____ Driver's License # _____

Insurance Information

First Insurance _____ Group # _____

Name of Policy Holder _____ Relationship to Patient _____

Birthdate _____ ID or SS # _____

Source of Insurance (i.e. Union #, Employer, etc.) _____

Second Insurance _____ Group # _____

Name of Policy Holder _____ Relationship to Patient _____

Birthdate _____ ID or SS # _____

Source of Insurance (i.e. Union #, Employer, etc.) _____

I hereby authorize payment to Heritage Dental Centers of benefits payable to me under the above policy. I also authorize Heritage Dental Centers to release to the above insurance all information needed to process claims.

Signature of Insured Person _____ Date _____

Service Charge Notice

I understand and agree that any charges remaining unpaid for longer than 60 days will be assessed a carrying charge of .67% a month. This is an annual percentage rate of 8%.

Signature of Responsible Party _____ Date _____

Financial Responsibility

I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services. I understand that I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid; in whole or in part, by by dental care payor.

I further understand that, if collection costs are incurred by Heritage Dental Centers for payment of my unpaid balance, I am responsible for payment of all charges.

Signature of Responsible Party _____ Date _____

Emerg. Contact

Name of nearest relative not living with you _____

Relationship _____ Phone _____

HELP US IMPROVE

How did you find out about Heritage Dental Centers? r Yellow Pages r Direct Mail r Web Site

r Referral; whom may we thank? _____ Relationship _____

r Sign/Location r Insurance r Other _____

Why did you choose Heritage Dental Centers? r Expertise r Location r Hours

r Cosmetic Dentistry r Services r Cost r Other_____

Contact Info.

What is your preferred method to be contacted? r E-mail r Cell Phone r Home Phone

r Text Message r US Mail (you may check more than one option)

***THIS INFORMATION WILL NOT BE SOLD OR USED FOR OTHER PURPOSES ***