PATIENT REGISTRATION

PATIENT FIRST NAME: _____ LAST NAME: _____ MI: _____

PREFERRED NAME:_____ DATE OF BIRTH: ___-___-_____ MARITAL STATUS: _____

MAILING ADDRESS:_____

CITY: _____ STATE: _____ ZIP: _____

SOCIAL SECURITY#: _____-___-_____ HOME PHONE: ____-____-____ WORK PHONE: ____-____-____ EXT: ____

MOBILE PHONE #: _____-_____-_____ SEX: _____ E-MAIL: _____

EMPLOYMENT STATUS: FULL TIME PART TIME RETIRED STUDENT

EMPLOYER NAME & ADDRESS:_____

RESPONSIBLE PARTY

FIRST NAME: _____ LAST NAME: _____ MI: _____

DATE OF BIRTH: ____-____-____ MARITAL STATUS: _____ SOCIAL SECURITY NUMBER: ____-___-____

MAILING ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: ____-____-____ WORK PHONE: ____-____-____ EXT: _____ MOBILE PHONE #: ____-____-____

E-MAIL: _____ EMPLOYMENT STATUS: FULL TIME PART TIME RETIRED STUDENT

EMPLOYER NAME & ADDRESS: _____

INSURANCE INFORMATION

PRIMARY INSURANCE PLAN NAME: _____CUSTOMER SERVICE TELEPHONE# ____-_____-____

MEMBER ID#:_____ GROUP#: _____

NAME OF POLICY HOLDER/EMPLOYEE: _____

FULL HOME ADDRESS: _____

EMPLOYER NAME & ADDRESS: _____

PATIENT RELATIONSHIP TO POLICY HOLDER: _____ INSURED DOB: ___-____-____ SSN: ___-____-____

SECONDARY INSURANCE

SECONDARY INS PLAN NAME: _____CUSTOMER SERVICE TELEPHONE# ___-___-____

MEMBER ID#:_____ GROUP#: _____

NAME OF POLICY HOLDER/ EMPLOYEE: _____

FULL HOME ADDRESS: _____

EMPLOYER NAME & ADDRESS: _____

PATIENT RELATIONSHIP TO POLICY HOLDER: _____ INSURED DOB: ___-___-____ SSN: ___-___-_____

COSMETIC INFORMATION

Do you like the appearance of your teeth? _____

Do you have any missing teeth? _____ Are any chipped or broken? _____

Is your bite comfortable when chewing or biting? _____

Do you have frequent headaches? _____

Do your gums ever bleed? _____

Do you have any old fillings or dental treatment that you are unhappy with? _____

Would you like your teeth to be whiter? _____

Is there anything else that you would like us to know? _____

_____

_____

WE ROUTINELY USE LATEX PRODUCTS FOR YOUR SAFETY. IF YOU HAVE A KNOWN SENSITIVITY TO LATEX PRODUCTS, PLEASE NOTIFY US PRIOR TO BEING CALLED BACK TO THE TREATMENT ROOM.

HOW DID YOU HEAR ABOUT OUR OFFICE? _____

To the best of my knowledge, all of the preceding information provided is true and correct. If I ever have any change in my personal information, I will inform the doctor or staff on or before my next appointment.

Signature of patient, parent or guardian: _____ Date: _____

Signature of Doctor: _____ Date: _____

CONSENT FOR SERVICES

I hereby authorize Dr. Weimer and/or staff to take x-rays, models, photographs and other diagnostic aids deemed appropriate by Dr. Weimer to make a thorough diagnosis of my/my child's dental needs. Upon such diagnosis, I authorize Dr. Weimer to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I agree to the use of anesthetics, sedatives and other medication, as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask the Doctor for a complete recital of any possible complications.

I understand that as a condition of my treatment by this office, financial arrangements must be made in advance. The practice depends upon payment from patients for the costs incurred in their care, and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid in full at the time treatment is rendered.

If I carry dental insurance, I understand that all dental services provided are charged directly to me and I am personally responsible for payment. After proper information is provided, Dr. Weimer's office will help prepare and submit the patient's insurance claims and assist in making collections from the insurance company and credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I understand and agree that a service charge of 1.75% per month (21% per annum) on the unpaid balance will be charged on accounts exceeding sixty (60) days, unless previously written financial arrangements have been made.

I understand that any fee estimate provided by this office for my dental care can only be extended for a period of ninety (90) days from the date of the patient examination.

In consideration for the professional services to me at my request by Dr. Weimer, I agree to pay the amount charged for said services to Dr. Weimer or her assignee, at the time said services are rendered, or within five (5) days of billing-if credit has been extended. I further agree that the reasonable value of said services shall be as billed, unless objected to by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I agree to pay all collection agency fees and all reasonable attorney fees incurred if suit is instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home, at any and all numbers given or at my work to discuss matters related to this form.

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

Signature of patient, parent or guardian: _____ Date: _____

Relationship to Patient: _____

Signature of Guarantor of payment/responsible person: _____ Date: _____

Relationship to Patient: _____