Confidential

Patient Registration Information

Date _____

Name _____ Patient #_____
First M.I. 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!

Home Address _____ City _____ State _____ Zip _____
Birthdate _____ Home Phone _____ Work Phone _____
E-Mail _____ Cell Phone _____
Do you prefer to receive calls at: ☐ Work ☐ Home ☐ Cell
Whom may we thank for referring you to our practice? _____

Are you: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
Your 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 _____
Person to contact in case of an emergency _____ Phone _____

Responsible Party

Name of person responsible for this account _____ Relationship _____
Address _____ Home Phone _____
City _____ State _____ Zip _____ SS #/SIN _____
Driver's License # _____ State _____ Birthdate _____
E-Mail _____ Cell Phone _____
Employer _____ Work Phone _____
Is this person currently a patient in our office? ☐ Yes ☐ No

Insurance/Benefit Information

Name of insured _____ Birthdate _____
Relationship to patient _____ SS #/SIN _____ Date Employed _____
Employer _____ Work Phone _____
Employer Address _____ City _____ State _____ Zip _____
Insurance Company _____ Group# _____
Ins. Co. address _____ City _____ State _____ Zip _____
How much is your deductible? _____ Max. annual benefit? _____ How much have you used? _____

Additional Insurance/Benefits

Do you have any additional insurance/benefits? ☐ Yes ☐ No If yes, complete the following:

Name of insured _____ Birthdate _____

Relationship to patient _____ SS #/SIN _____ Date Employed _____

Employer _____ Work Phone _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group# _____

Ins. Co. address _____ City _____ State _____ Zip _____

How much is your deductible? _____ Max. annual benefit? _____ How much have you used? _____

Authorization, Release, and Agreement to Pay For Services Rendered

I authorize William L. Tucker, DDS, PLC 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 my insurance company to pay directly to William L. Tucker, DDS, PLC insurance benefits otherwise payable to me.

I understand that my dental insurance carrier or benefit provider may pay less than the actual bill for services received. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents.

✗ _____ _____

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 that 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

_____ Credit Card: _____ Visa _____ MasterCard

Card # _____ Expiration Date _____ Security Code_____

Late Charges

If I do not pay the entire new balance within 25 days of the monthly billing date, a late charge of 1.5% on the balance then unpaid and owed in addition to a duplicate billing fee will be assessed each month as allowed by law. I realize that failure to keep this account current may result in you being unable to provide additional dental services except for dental emergencies or where there is prepayment for additional services. In case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances. Patient/Parent/Guardian Initials: ✗_____

Thank you for filling this form out completely. The information you have provided will help us serve your dental healthcare needs more effectively and efficiently. If you have any questions at any time, please ask us. We are always happy to help.