

## Patient Registration

### Patient Information

Name: \_\_\_\_\_ M F  
Last Name First Name MI Sex

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ SS# \_\_\_\_\_ Driver's License# \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

Phone #'s: Home (\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_

Email Address: \_\_\_\_\_ Employer: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

How did you hear about our office:  Friend/Family \_\_\_\_\_  Ad \_\_\_\_\_  
 Insurance Plan  Google  Yahoo  Website  Sign  Facebook  YP.com  Other \_\_\_\_\_

### Responsible Party: The person who is responsible for this account

Name: \_\_\_\_\_  
Last Name First Name Relationship

Address: \_\_\_\_\_  
Street City State Zip

Phone #'s: Home (\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_

SS# \_\_\_\_\_ Driver's License # \_\_\_\_\_ Employer: \_\_\_\_\_

### Insurance Agreement

*Patients with dental insurance understand that all services are charged directly to the patient and that he or she is ultimately responsible for payment of all services. It is your responsibility to notify us of any change in your insurance coverage or benefits to insure timely submission of claims. Our office will gladly prepare the insurance forms to assist in obtaining payment from insurance companies and will accept payments directly to our office. Insurance benefit calculations provided by our office are done as a courtesy and are not a guarantee of coverage. Denied services, payments that differ from the estimated payment or claims not paid within 60 days of submission are your responsibility. If a more definitive estimate of your insurance benefits is desired please request a submission for Predetermination of Benefits before treatment begins.*

### Financial Policy

*Payment for services provided by Courtyard Dental Care is due the day services are rendered, unless prior arrangements have been made. If you are interested in learning more about our payment options please ask our expert staff before treatment begins. All balances not paid as agreed are subject to 1 ½ % per month (annual rate 18%) until paid in full.*

\_\_\_\_\_  
Signature of Patient (over 18 years of age) or Legal Guardian (if under 18 years of age) Date