The Main Street Dentists

PATIENT REGISTRATION

PATIENT NAME:_____ **Date**:_____
***Home Phone**:_____ **Cell Phone**:_____

***Physical Address**:_____ Apt#:_____
City:_____ State:_____ Zip:_____

***Mailing Address**:_____Apt#:_____
City:_____ State:_____ Zip:_____

(if seasonal resident)
***Secondary Address**:_____ Apt#:_____
City:_____ State:_____ Zip:_____

***Date of Birth**:_____ **Age**:_____ Check One: **Male**_____ **Female**_____
***S.S**.#_____ **Drivers' License** #:_____**State**:_____

***Patient's Place of Employment**:_____ Business Phone:_____

***Physician's Name**:_____ Phone:_____
Physician's Address:_____

(circle one)
***Spouse/Parent/Guardian Name**:_____ Phone:_____
Address:_____
Spouse/Parent/Guardian Place of Employment:_____ Business Phone:_____

***In Case of Emergency, Call**:_____Phone:_____

>Person Responsible for Payment:_____**Relationship**:_____
…Home Phone:_____Cell Phone:_____
…Physical Address:_____ Apt#:_____
City:_____ State:_____ Zip:_____
…Mailing Address:_____Apt#:_____
City:_____ State:_____ Zip:_____
…Place of Employment:_____ Business Phone:_____

+Method of Payment: Cash:___ Check:___ Credit Card:___ Insurance Company:_____
~Referred By:_____

PAYMENT-IN-FULL IS DUE WHEN SERVICES ARE RENDERED

Cash, local personal checks, Money Orders, Discover, Master Card, and Visa are accepted. PLEASE NOTE: If Patient has dental insurance, insurance filing is done only as a courtesy and not as a guarantee of payment or benefits. Patient must pay their portion at the time services are rendered. If insurance has not paid on your insurance claim within 60 days, Patient is then immediately responsible for the total amount due. Also, if insurance coverage cannot be verified or is unclear, Patient must pay full amount due on date of service. Patient is always ultimately responsible for total amount of all charges.

I, the undersigned Patient, or as the legally responsible party for the Patient, hereby authorize dental treatment and assume financial responsibility for any and all dental treatment and services agreed to and provided by ***The Main Street Dentists*** to and for the Patient, and hereby acknowledge that I fully and completely understand that I am responsible for all financial obligations and hereby agree to make payment-in-full due to ***The Main Street Dentists***. I have received a copy of ***The Main Street Dentists***' PAYMENT POLICY. All above-shown information I have provided is true and correct.

Patient Signature:_____ Date:_____
Responsible Party Signature:_____ Date:_____
Printed Name of Responsible Party:_____