ADULT PATIENT REGISTRATION

☐Mr ☐Ms ☐Rev ☐Dr Print Name: ____

Date of Birth: __________ Preferred Name: ____________ ☐Male ☐Female ☐Other

Mailing Address: __________________________ City:__________ State:_____ Zip:________

Home Phone # ___________ Work Phone # _____________ Cellphone # _______________

Email address: ____________________________

For appointment reminders, contact me by: ☐Email only ☐Email and text ☐email and phone ☐Phone only

Emergency contact information

Name: _________________________________ Relationship to patient _____________

Phone # ___________ Other phone # _______________

Responsible party Information:

Name: _________________________________ Relationship to patient_____________

Address(if different from patient): ____

Employer: _________________________

Dental Insurance: ___________________________ ID # _______________

Patient Treatment Consent/Agreement

Consent to Treatment The undersigned consents to radiographs (x-rays), laboratory procedures, anesthesia, diagnostic tests, dental treatment, or other procedures rendered to the patient. Although the undersigned may elect not to undergo certain specific procedures, without adequate diagnosis or treatment plan, Healthy Smiles Family Dentistry (HSFD) may decline to treat the patient.

Privacy Practices Our Notice of Privacy Practices is available to the undersigned via our website or in paper form by request. The undersigned consents to the use and disclosure of his/her health information to carry out treatment and health care operations. The undersigned has the right to revoke consent at any time by written notice; however, we may decline to treat the patient if this consent is revoked.

Financial Agreement The undersigned agrees, whether he/she signs as agent or as patient, he/she hereby individually obligates himself/herself to pay for treatment received. Failure to pay for services in a timely manner may jeopardize the patient's access to routine dental care. In the event the patient’s account is transferred to a bad debt collection agency the undersigned may be responsible for reasonable attorney's fees and collection expenses.

Minors and Dependent Adults The parent (or legal guardian) of patients under the age of 18 (or dependent adults) must be registered as the guarantor; the guarantor’s name and physical address is required. Either parent may be held responsible for payment of treatment rendered to their minor child or dependent adult. Our policy is to bill the parent/legal guardian who presented the minor/dependent adult for treatment. The same applies to minors/dependent adults of divorced parents.

Insurance Healthy Smiles Family Dentistry submits to insurance as a courtesy to our patients; balances after insurance are billed to the guarantor. Ultimately, the guarantor is responsible for payment, regardless of the insurance carrier’s consideration.

The undersigned authorizes Healthy Smiles Family Dentistry to submit claims (on the patient's behalf) to insurance or other third party payer(s) and to disclose health information to the extent necessary to obtain payment. The undersigned also assigns benefits paid by insurance directly to Healthy Smiles Family Dentistry.

I have reviewed the Financial Policy as stated above and I understand and accept responsibility of cooperating with these policies. I understand that I will be responsible for financial balances resulting from treatment received that is not paid by my insurance company or any third party agency. My signature acknowledges that I understand and accept the above agreement.

Signed: _____________________________ Date: ______________________

Printed: _____________________________ Relationship to patient: ____________