OAK PARK DENTAL

Enhancing your life, health and smile.

PATIENT REGISTRATION

ID:_____ Chart ID:_____

First Name: _____ Last Name:_____ Middle Initial:_____

Patient is: ❍ Policy Holder ❍ Responsible Party Preferred Name: _____

Responsible Party (if someone other than the patient)

First Name: _____ Last Name:_____ Middle Initial:_____

Address:_____ Address 2: _____

City, State, Zip:_____ Pager:_____

Phone: (H) _____ (W) _____Ext:_____ (C) _____

Birth Date: _____ SSN:_____ Driver's Lic:_____

❍ Responsible Party if also a Policy Holder for Patient ❍ Primary Insurance Policy Holder ❍ Secondary Insurance Policy Holder

Patient Information

Address:_____ Address 2: _____

City, State, Zip:_____ Pager:_____

Phone: (H) _____ (W) _____Ext:_____ (C) _____

Sex: ❍ Male ❍ Female Marital Status: ❍ Married ❍ Single ❍ Divorced ❍ Separated ❍ Widowed

Birth Date: _____ Age:_____ SSN:_____ Driver's Lic:_____

E-mail: _____ ❍ I would like to receive correspondence via e-mail.

Section 2

Employment Status: ❍ Full Time ❍ Part Time ❍ Retired

Student Status: ❍ Full Time ❍ Part Time

Medicaid ID: _____ Pref. Dentist: _____

Employer ID: _____ Pref. Pharmacy: _____

Carrier ID: _____ Pref. Hyg.: _____

Section 3

Additional Comments:

Primary Insurance Information

Name of Insured: _____

Relationship to Insured: ❍ Self ❍ Spouse ❍ Child ❍ Other

Insured SSN:_____ Insured Birth Date: _____

Employer:_____

Address:_____

City, State, Zip_____

Insurance Company: _____

Address: _____

_____

City, State, Zip _____

Rem. Benefits: _____.00 Rem. Deduct:_____.00

Secondary Insurance Information

Name of Insured: _____

Relationship to Insured: ❍ Self ❍ Spouse ❍ Child ❍ Other

Insured SSN:_____ Insured Birth Date: _____

Employer:_____

Address:_____

City, State, Zip_____

Insurance Company: _____

Address: _____

_____

City, State, Zip _____

Rem. Benefits: _____.00 Rem. Deduct:_____.00

PATIENT REGISTRATION

Who can we thank for referring you to our practice? _____

Emergency contact person:_____

Relationship: _____

Home phone:_____ Work phone: _____

CONSENT FOR TREATMENT & FINANCIAL AGREEMENT

I, the undersigned, hereby authorize Oak Park Dental to take radiographs, study models, photographs, records or any other diagnostic aids he/she deems appropriate to make a thorough diagnosis of my dental needs. I also authorize Oak Park Dental to perform any and all forms of treatment, medication and therapy that may be indicated. I authorize and consent Oak Park Dental to employ any such assistance as he/she deems appropriate under the law. I further authorize the release of diagnosis, radiographs, patient records, treatments or examinations render: to my insurance company, consulting professionals and others I approve.

I understand that I am personally responsible for payment of all fees for dental services provided in this office for me or my dependents, regardless of insurance coverage. Breach of this responsibility carries the penalty of compensating the practice for any related attorney's and collection fees. Reservations require a great deal of setup and preparation tailored to you and your treatment. Last minute cancellations and missed reservations will be charged $50.00 per half hour scheduled. To avoid this charge, contact our office within 48 hours of your reservation. We do understand that, on occasion, last minute things do occur. If we both take our commitment to each other seriously, these issues are often avoidable.

I certify that the information given is correct and current. I am aware that it is my responsibility to read and understand my own dental insurance policy, including benefits, limitations and exclusions. I understand that filing of insurance claims is my responsibility and may be provided as a service to me and that any agreement for dental coverage is between my insurance company and myself. I understand that an estimated portion is due at time of service and is estimated according to expected coverage, which may not be disclosed nor guaranteed by my insurance company. I understand my portion may be more if my insurance company does not pay the anticipated amount. I also understand that services are rendered independent of insurance reimbursement. Reservations require payment in full unless approved arrangements have been made returned checks will be charged $30. I have also received a copy of the Privacy Policy.

Pre-Payment Discount -- A discount of 5% is given to Cash or Check payments, if reservation is paid in full 7 or more days prior to treatment. This 5% discount does not apply to patients with Insurance or patients that are enrolled in the Dental Benefit Program.

We accept Visa, MasterCard, Discover and Care Credit; however, no discounts will be given to these forms of payment. Financing is available OAC.

_____ _____

Patient/Guardian Signature Date

_____ _____

Print Name Relationship to Patient