PATIENT REGISTRATION

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

Preferred Name: _____ Preferred Pronoun: ☐ He ☐ She ☐ They

Address: _____ Apt: _____ City: _____ State/Zip: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cell Phone: _____

Birth Date: _____/_____/_____ Soc Sec: _____--_____--_____

Email: _____

Whom can we thank for referring you? _____

OFFICE PROTOCOLS

Broken/Cancelled Appointments: We are very appreciative of patients who arrive on time for their scheduled appointments. In the unlikely event you need to cancel an appointment, we request notice at least 24 hours in advance of the appointment. As a courtesy, our office may contact you to remind you of the appointment(s). While certain emergencies and other issues may be taken into consideration, Dental Masters of Ravenswood reserves the right to apply a fee of $50 to your account for failure to provide adequate notice.

Guarantee of Payment/Assignment of Insurance Allowances: Unless otherwise stated, I understand that fees are due for any services rendered on the date of service. I authorize payment for services rendered to me to be made directly to this office for allowances otherwise payable to me. These payments shall not exceed the regular charges for this period of treatment. I also understand that I am responsible to pay any charges not covered through my insurance allowances, including but not limited to non-covered services, applicable deductible and/or co-insurances as defined by my policy(ies), or any fees for services in the event that I do not have insurance coverage.

Completion of Treatment: In the event that I elect to receive treatments such as crowns, dentures, root canals, bridges, implants and other treatment that requires me to return for future visits to finalize, I understand that I am responsible to return to the office to complete treatment. These types of treatments typically require Dental Masters of Ravenswood to incur lab, equipment, and labor costs up front. In the event that I do not return to complete the treatment, I understand that I am still responsible to pay the full cost of the treatment.

Past Due Balances & Collection Services: Dental Masters of Ravenswood makes an effort to provide all patients with education and information regarding proposed and completed treatment, as well as the costs associated, in order for each patient to make an informed decision regarding their treatment. I understand that should my past due balance be referred to an attorney or collection agency, I will be financially responsible for any additional costs incurred such as attorney fees, collection agency fees, court costs, etc.

I agree to abide by the protocols listed above. I understand that if I have any questions about these protocols, I may request assistance and further explanation at any time from a Dental Masters of Ravenswood team member.

_____ _____

PATIENT/RESPONSIBLE PARTY NAME DATE

_____

PATIENT/RESPONSIBLE PARTY SIGNATURE