

PATIENT REGISTRATION

NAME _____ PREFERRED NAME: _____ DATE OF BIRTH _____
SOCIAL SECURITY NO. _____ MARITAL STATUS: S M W D
STREET ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____
PHONE (H) _____ (W) _____ REFERRED BY: _____
OCCUPATION/
EMPLOYER _____ ADDRESS: _____
SPOUSE/
PARENT NAME: _____ SPOUSE/PARENT
OCCUPATION/EMPLOYER _____
EMERGENCY CONTACT: _____ PHONE: _____

BILLING & INSURANCE INFORMATION

BILLING NAME
IF OTHER THAN PATIENT _____ RELATIONSHIP _____ DATE OF BIRTH _____
BILLING/MAILING
ADDRESS _____ CITY _____ STATE _____ ZIP _____
SOCIAL SECURITY NO. _____ PHONE: _____
PAYMENT METHOD: CHECK CASH CREDIT CARD INSURANCE

PRIMARY INSURANCE COVERAGE

SECONDARY INSURANCE COVERAGE

INSURED'S NAME _____ INSURED'S NAME: _____
EMPLOYER: _____ EMPLOYER: _____
S.S. # _____ DOB _____ S.S.# _____ DOB _____
INSURANCE CO. _____ INSURANCE CO. _____
ADDRESS _____ ADDRESS _____
CITY/STATE/ZIP _____ CITY/STATE/ZIP _____
CONTRACT/GROUP _____ CONTRACT/GROUP _____

PAYMENT POLICY

DR. DUNAVANT DOES NOT PARTICIPATE IN ANY PREFERRED PROVIDER ORGANIZATION. CHARGES FOR INITIAL VISIT, WHETHER EXAMINATION OR EMERGENCY ARE PAYABLE AT THE TIME SERVICES ARE RENDERED. WE WILL FILE AN INSURANCE CLAIM FOR REIMBURSEMENT TO YOU OR PROVIDE YOU WITH A COPY TO FILE YOURSELF. FOR PROFESSIONAL FEES COVERING TREATMENT RENDERED SUBSEQUENT TO YOUR INITIAL VISIT, WE WILL ACCEPT INSURANCE BENEFITS PAID DIRECTLY FROM YOUR INSURANCE COMPANY. HOWEVER YOU ARE RESPONSIBLE FOR THE DEDUCTIBLE AND CO-PAYS AT THE TIME OF SERVICES. PLEASE CONSULT WITH OUR BUSINESS ASSISTANT CONCERNING ANY NEED FOR PARTIAL PAYMENT. FEES NOT PAID WITHIN 60 DAYS ARE SUBJECT TO A PAST-DUE BILLING CHARGE OF \$2.00 PER MONTH OR 1.5% PER MONTH, WHICHEVER IS GREATER. IF IT IS NECESSARY TO COLLECT UNPAID FEES FOR SERVICES RENDERED TO THE PATIENT, ALL COSTS OF COLLECTION FEES AND EXPENSES WILL BE ADDED TO YOUR BALANCE.

RELEASE

I AUTHORIZE THE DENTIST TO PERFORM DIAGNOSTIC PROCEDURES AND TREATMENT AS MAY BE NECESSARY FOR PROPER DENTAL CARE. I AUTHORIZE RELEASE OF ANY INFORMATION CONCERNING MY (OR MY CHILD'S) HEALTH CARE AND TREATMENT TO ANOTHER DENTIST. I HEREBY AUTHORIZE PAYMENT OF INSURANCE BENEFITS DIRECTLY TO THE DENTIST OTHERWISE PAYABLE TO ME. I UNDERSTAND THAT MY DENTAL INSURANCE CARRIER OR PAYOR OF MY DENTAL BENEFITS MAY PAY LESS THAN THE ACTUAL BILL FOR SERVICES. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR PAYMENT IN FULL OF ALL ACCOUNTS. BY SIGNING THIS STATEMENT, I REVOKE ALL PREVIOUS AGREEMENTS TO THE CONTRARY AND AGREE TO BE RESPONSIBLE FOR PAYMENT OF SERVICES NOT PAID IN WHOLE OR IN PART BY MY DENTAL CARE PAYOR.

PATIENT/GUARDIAN SIGNATURE: _____ DATE: _____