PRIMERA DENTAL

1045 Primera Blvd, Suite 1001, Lake Mary, FL 32746 - Ph. 407-512-5700

Patient Registration

Today's Date: _____

Last Name _____ First Name _____ MI _____ Date of Birth _____ Age __
Sex M or F _____ Soc. Sec. # _____ Please Select One: ◯ Single ◯ Married ◯ Separated ◉ Widow
Mailing Address _____ City _____ State ____ Zip Code _____
Home Phone (___)_____ Cell Phone (_____)_____ Email _____
Occupation _____ Employer _____
Work Phone (_____)_____ Driver's License # _____
Are you a full time student? Yes or No If Patient is a minor: Mother's DOB _____Father's DOB _____
Name of Parent _____ Parent Soc. Sec. # _____
Parent Employer _____ Parent Phone (_____)_____
Person Responsible for Account _____ Relationship _____
Emergency Contact _____ Relationship _____ Phone # (_____)_____
If you are filling this form out on behalf of another person, what is your relationship to that person?
Name _____Relationship _____
How did you hear about us? _____ Reason for today's visit? _____

Dental Insurance Information (Primary Carrier)	Dental Insurance Information Secondary Coverage
Insured's Name _____	Insured's Name _____
Insured's Employer _____	Insured's Employer _____
Insured's DOB _____	Insured's DOB _____
Insurance Co _____	Insurance Co _____
Insurance Co Address _____	Insurance Co Address _____
Insurance Phone # _____	Insurance Phone # _____
Group # _____ Local # _____ ___	Group # _____Local # _____

FINANCIAL POLICY

Thank you for choosing our office as your dental healthcare provider. We are committed to providing you with the highest quality lifetime dental care, so that you may attain optimum oral health. The following is a statement of our financial policy, which we require that you read, agree to, and sign prior to any treatment. Payment is due at the time service is provided.
Our office accepts cash, personal checks, credit cards and outside patient financing.
Please check if you would like more information about financing options.
Please Note: Returned checks will be subject to additional fees. In the case it becomes necessary for our office to enlist a collection service and/or legal assistance, you will be responsible for any collection and/or legal charges up to 35%.

Do You Have Insurance?
As a courtesy to you we will help you process all your insurance claims. Please understand that we will provide an insurance estimate to you, however, it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits will determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible.
All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company. Our office is not a party to that contract.
Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.
We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office.
If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected.
If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.
We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office.
We ask that you pay the deductible and co-payment, which is the estimated amount, not covered by your insurance company, by cash, check, credit card or Patient Financing at the time we provide the service to you.
We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.

We thank you for the opportunity to serve your dental health care needs and welcome any question you may have concerning your care or our financial policy.

Consent:

I have read, understand and agree to the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to my dental office. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a finance, rebilling, collection charge and/or attorney fee will be added to any overdue balance. By signing below, you are authorizing us to call you at any number you provide including calls to mobile/cellular or similar devices for any lawful purpose. You agree to any fees or charges that you may incur for an incoming call from us, and/or outgoing calls to us, to or from any such number, without reimbursement from us.

_____ _____
Patient Signature (Parent if child) Date