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 Circle 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? _____

_____

Please provide us with a copy of your current insurance card

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 # _____

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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

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Fax: 407-512-6579

Office Policies

Our office policies statement is designed with you, the patient, in mind. It is written to answer any questions you may have regarding how our office treats scheduled appointments, cancelled appointments, late arrivals, dental emergencies, and weekend emergencies.

Appointments

We are dedicated to staying on schedule and seeing all of our patients on time for their appointments. We do ask that our patients be on time for scheduled appointments, planning extra time for travel or filling out forms. We recommend arriving 5-10 minutes early to ease the check in process. Please be aware that dental emergencies do arise throughout the day which may delay or extend your appointment. We are committed to treating all true dental emergencies and will advise you immediately as to the status of your appointment.

_____ **Initial**

Late Policy

We expect our patients to arrive on time for their scheduled appointment. Please note that we may have to reschedule your appointment if you arrive more than 15 minutes late.

_____ **Initial**

Cancellations

We reserve time especially for you, for your appointment. If you need to change your appointment, we kindly request **two business days** notice when rescheduling. **Cancellations WILL NOT be accepted through text messaging, email or voicemail. Should you cancel after the 48 hours, please be advised that you may be charged a broken appointment fee in the amount of $45 per missed hygiene appointment and $45 per hour of doctors appointments.** Consecutive missed appointments can result in being dismissed as a patient.

_____ **Initial**

Emergencies

If you have an urgent problem, please call our office immediately so we may see you as soon as possible. If you have an after hour emergency, please call the office and leave a voicemail so that we can contact the doctor.

_____ **Initial**

Weekend and After Hours

Patients of record with true dental emergencies after regular business hours, which cannot wait until the following day, should call our office and leave a voicemail. Someone will return your call promptly.

_____ **Initial**