Milwaukee DENTAL ARTS

PATIENT REGISTRATION

Patient Information

Name: _____ Birthdate: _____

Address: _____

City State Zip Code

Phone Number: _____ Sex: _____ (Circle) Married Single Minor

Who may we thank for referring you? _____

In case of emergency who should be notified? Name _____ Phone # _____

Last visit to the dentist? _____

Person responsible for Account _____ Social Security #: _____

Primary Insurance

Primary subscriber Name: _____ Birthdate: _____

Social Security #: _____ Phone #: _____

Address (if different from patient's): _____

Employer: _____

Insurance Company: _____

Additional Insurance

Is patient covered by another insurance? _____

Subscriber Name: _____ Birthdate: _____

Social Security #: _____

Employer: _____

Insurance Company: _____

Confirmation of Appointments

Out of courtesy to our patients we contact our patients at least one day prior to the appointment to confirm that you will be here for your scheduled dental appointment. Please indicate below how you would like for us to confirm your appointments.

By Phone: _____ Phone # _____ is this home/work/cell/other

By Email: _____ Your email address: _____

No thanks, I don't need a reminder: _____ Initials: _____

Milwaukee DENTAL ARTS

Our practice is dedicated to your quality care and is pleased to schedule appointments for you that accommodate the busy scheduling needs of all our patients. In return, we ask that patients make every effort not to change their scheduled dental appointments. We require a minimum of a 24-hour notice so that we may accommodate another patient. **A $50.00 charge will be applied for broken and missed appointments without advanced notification.** Thank you for your cooperation and for allowing us to serve all of our patients.

I agree and understand this missed/ broken appointment policy:

Patient/ Guardian Signature _____ Date _____

Certification

To the best of my knowledge, the information provided on this form is complete and correct. I understand it is my responsibility to inform if there are any changes in my health or minor child's health.

Minor/Child Consent

I am the parent, guardian, or personal representative of (please print name of minor/child) _____ _____ and there are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize the dental staff to perform necessary dental services for the child named above, including but not limited to x-rays, and administration of anesthetics, which are deemed advisable by the doctor, whether I am present when the treatment is rendered.

Insurance Assignment and Release

I certify that my dependent(s) and I are covered by insurance with (Name of insurance Company(ies))_____ _____ and assign directly to Dr. Vargas all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my minor/child's health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when the current treatment plan is completed or one year from the date signed below.

Financial Agreement

I acknowledge that **payment for any co-pay, portion and/or deductible is due at the time of treatment,** I agree that parents, guardians, or personal representatives are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for services or items provided to me or the patients. I understand that filing a claim with my insurance company does not relieve me of my responsibility for the payment of all charges that my insurance company does not pay for.

_____ _____

Signature of Parent, guardian, or personal representative | Date

_____ _____

Please print name of parent, guardian, or personal representative | Relationship to patient