west end dental
comprehensive & aesthetic dentistry

Patient Registration

First name: _____Last name: _____Middle Initial: _____

If minor, name of parent(s):_____

How would you like to be addressed? _____

Birth Date: _____ Age: _____ Soc. Sec: _____

Address: _____

City, State, Zip: _____

How do you prefer being contacted by our office? (Please check preference)

□ Home phone :(____) _____-_____ □ Work phone: (____) _____-_____□ Cell: (____) _____-_____

□ Email address: _____

Sex: □ Male □ Female Marital Status: □ Married □ Single □ Divorced □ Separated □ Widowed

Name of Employer: _____

Someone to notify in case of an emergency: _____Phone:_____

Who referred you to our office? _____

Insurance Information (please provide insurance card)

Name of Policy Holder: _____ Policy Holder Birth Date: _____

Relationship of Patient: □ Self □ Spouse □ Child □ Other _____

Subscriber ID #_____ Group #_____

Name of Policy Holder's Employer: _____

Name of Insurance Company: _____ Phone: _____

Address: _____City, State, Zip: _____

Cancellation Policy:

If you fail to show for an appointment, cancel, or reschedule less than 24 hours prior to your scheduled appointment time, our office reserves the right to charge your patient account a fee of $41.00.

Financial Policy:

I hereby authorize West End Dental to furnish information to insurance carriers concerning my treatment, and I authorize insurance benefit payments directly to West End Dental. I understand that I am financially responsible for the payment of all services rendered. West End Dental charges 1.5% (18% annual interest, minimum of $3.00/month) on accounts with a balance 90 days past due.

I attest to the accuracy of the information on this page. I agree to the cancellation and financial policy.

Signature_____ **Date**_____