

Jeffrey D. Carl, DMD PC Christopher D. Walker, DMD

PATIENT REGISTRATION (PLEASE PRINT)

Date: _____

Patient: _____
Last Name First Name Middle Initial Preferred Name

Street Address: _____ City: _____ State: _____ Zip: _____

E-mail: _____ Home Ph: (____) _____ Cell Ph: (____) _____ Work Ph: (____) _____

Sex: M F Age: _____ Birthdate: _____
 Married Widowed Single Minor
 Separated Divorced Partnered for ____ years.

PERSONS RESPONSIBLE FOR ACCOUNT

Name: _____ Birthdate: _____ Home Ph.: (____) _____

Address: _____ City: _____ State: _____ Zip: _____

Occupation: _____ SS #: _____ Work Ph: (____) _____ Ext.: _____

Employer: _____ Years Employed: _____ Driver's License #: _____

Name: _____ Birthdate: _____ Home Ph.: (____) _____

Address: _____ City: _____ State: _____ Zip: _____

Occupation: _____ SS #: _____ Work Ph: (____) _____ Ext.: _____

Employer: _____ Years Employed: _____ Driver's License #: _____

PRIMARY INSURANCE

Subscriber Name: _____ Birthdate: _____ Dependent Coverage Yes No

Subscriber Address: _____ SS #: _____

Ins.Co: _____ Employee ID#: _____

Ins. Co. Address: _____

Ins. Co. Phone #: _____ Group #: _____

SECONDARY INSURANCE

Subscriber Name: _____ Birthdate: _____ Dependent Coverage Yes No

Subscriber Address: _____ SS #: _____

Ins.Co: _____ Employee ID#: _____

Ins. Co. Address: _____

Ins. Co. Phone #: _____ Group #: _____

GETTING TO KNOW YOU

Who were you referred by? _____

List family member(s) or relative(s) who are patient(s) at our office: _____

Person to contact for emergency: _____ Ph.: (____) _____

Closest relative not living with you: _____

Address: _____ Ph.: (____) _____

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 or not I am present when the treatment is rendered. _____ **Initial**

TO OUR PATIENTS REGARDING PAYMENT AND APPOINTMENTS

1. Payment is due at time of treatment. We accept Cash (includes money orders and personal checks), VISA, Mastercard, American Express, CareCredit, and Citi Healthcard.
2. If your budget requires monthly payments, please discuss CareCredit or Citi Healthcard with our financial coordinator in the business office, before your appointment.
3. If you have dental insurance coverage, we ask you to pay any deductible and/or co-payment at the time of treatment.

FOR FIRST TIME PATIENTS -

If you have insurance, please provide us with complete information, including the address of your insurance and the birthdate of the insured on the back of this form. Bring your insurance card with you and we will photocopy it. We will bill your insurance as a courtesy to you. Please remember that your insurance is not our insurance. Any questions concerning your policy should be directed to your insurance company. We ask that you assign all insurance benefits directly to Jeffrey D. Carl, D.M.D., P.C. If you need further assistance, please call us. We are very happy to help you in any way possible.

If you do not have dental insurance, our office policy is that payment in full must be made at the time of treatment. If there is a need to make monthly payments, financial arrangements must be obtained, in advance, from CareCredit or Citi Healthcard. Our business office will assist you with these financing options. For accounts that go beyond 60 days a 1.5% monthly interest charge (18% per annum) will be assessed.

Our office policy is to obtain a credit report for financial purposes. Payment in full, at the time of treatment, will allow for 5% savings when paid at time of treatment with cash or check. We also offer a senior discount of an additional 5% for patients who are 65 or older.

You have my permission to request medical and dental records, (including X-rays), from any previous provider. _____ **Initial**

I acknowledge that I have received a copy of Dr. Carl and Dr. Walker's Notice of Privacy Practices. _____ **Initial**

APPOINTMENTS:

You may make appointments by calling **(541-926-6089)** Mon-Thur 8:00 am to 5 pm. Please call to cancel or reschedule 24 hours in advance or you will be charged the customary fee of \$50.00 per hour for a missed appointment. Your doctor sets aside time especially for you. Insurance companies will not cover or reimburse missed appointment charges.

We appreciate you for entrusting your dental health care to us. Thank you.

Signature _____

Date _____