Patient Registration

First Name:_____________________________Last Name:________________________Middle Initial:____

Preferred Name:__________________________________

Patient Information

Address:____

City, State, Zip:____

Home Phone:_____________________Work Home:____________________Cell:___________________

Birth Date:________________________________Soc Sec:_______________________________________

Sex: ◯ Male ◯ Female

Marital Status: ◯ Married ◯ Single ◯ Divorced ◯ Separated ◯ Widowed

E-mail:___________________________________ ◯ I would like to receive correspondences via e-mail

Employment Status: ◯ Full Time ◯ Part Time ◯ Retired

Student Status: ◯ Full Time ◯ Part Time School:_______________________________________

Pref. Pharmacy:___________________________Phone:____

Referred to Atrium Dental Group, Inc. by:____

Previous Dentist:____________________________________Last Visit:____________________________

Reason for leaving:____

Emergency Contact:_________________________Phone#:__________________________________

Dental Insurance Information

Primary Insurance Policy Holder:

First Name:____________________________Last Name:_________________________Middle Initial:____

Address:____

City, State, Zip:____

Birth Date:_________________________________Soc Sec:_____________________________________

Employer:__________________________________Group#:_____________ID#:______________________

I authorize my insurance to pay directly to Atrium Dental Group. I understand that all policies are different and I am responsible for knowing my plan provisions. I understand that I will be responsible for all co-payments, deductibles, and rejected charges. Please be aware that your insurance company may not pay for composite (tooth-colored) fillings at the same level as amalgam (silver-colored) fillings. The difference is your responsibility.

Signature of Policy Holder:____Date:___________________

Financial Policy

We are a “fee for service” dental practice. We thank you for paying for treatment on the day that services are rendered to you. We accept cash, check, Visa, Mastercard, Discover, and Care Credit. We ask that you provide us with at least 24 hour notice of any cancelled appointment, if you do not extend us this courtesy a cancelation fee will be applied to your account. Past due accounts are subject to a monthly service charge of 1.5% and will be turned over to a collection agency or small claims court. You agree to pay any and all attorney fees associated with the collection of monies due. Returned checks are subject to a $30.00 charge if returned by your bank for any reason.

Signature of Responsible Party:____Date:____________________