

ADULT REGISTRATION FORM

Patient's Name _____ Preferred Name _____

Birthdate _____ Age _____ Gender: Male Female

Marital Status: Single Married Widowed Divorced Separated

Social Security Number _____

Address _____ City _____ State _____ Zip _____

Phone Number _____ Cellular phone number _____

Message Number _____ **Email address** _____

Employer _____ Position _____ How Long? _____

Employer Address _____ Phone _____

City _____ State _____ Zip _____

Spouse's Name _____ SS# _____ Birthdate _____

Phone Number _____ Cellular phone number _____

Spouse's Employer _____ Phone _____

Employer Address _____

City _____ State _____ Zip _____

Who should we notify, other than spouse, in case of emergency?

Name _____ Relationship _____

Address _____ Phone _____

City _____ State _____ Zip _____

Previous Dentist _____ Phone _____

How did you hear about our office?

- Phone Book – Dex 1-800-DENTIST
- Phone Book – Hispanic Yellow Pages Family Member: _____
- Insurance Doctor's Office: Dr. _____
- Other: (Please specify) _____

Payment Information: *All services must be paid by cash, check or credit card as each service is provided.*
Patients with insurance or other coverage must complete all the required information.

(please continue on the back side)

Primary Insurance:

Subscriber's Name _____ SS# _____

Relationship of Patient: Self Spouse Child Birthdate _____

Insurance Company _____ Group# _____

Address _____ Phone _____

Secondary Insurance:

Subscriber's Name _____ SS# _____

Relationship of Patient: Self Spouse Child Birthdate _____

Insurance Company _____ Group# _____

Address _____ Phone _____

AUTHORIZATION FOR RELEASE OF INFORMATION: (All patients/guarantors must sign)

I certify that the above information is correct. I authorize release of any information relating to my dental claims. I understand that I am responsible for all costs of dental treatment. I hereby authorize payment of the group insurance benefits otherwise payable to me directly to Aesthetic Dental Center.

Patient Signature _____ Date _____

PERMISSION FOR TREATMENT: (All patients/guarantors must sign)

I hereby give my permission to Aesthetic Dental Center's dentists to provide dental treatment as deemed necessary.

Patient Signature _____ Date _____

PAYMENT AGREEMENT: (All patients/guarantors must sign)

I understand that my Insurance Policy is between the insurance company and myself and I am liable to Aesthetic Dental Center for services rendered. I also understand I will be furnished with an estimate regarding my insurance benefits at the onset of treatment.

I agree to pay Aesthetic Dental Center for all dental treatment at the time of service. I promise to pay my account until my balance has been paid in full. Should my account become past due, I will be charged 1.5% per month interest with \$25.00 late charge fee on the overdue amount. I also understand that should my account become delinquent, it may be turned over for collection, including any attorney's fees incurred.

Patient Signature _____ Date _____

Please remember that once an appointment has been made, this time is reserved specifically for you. No charge will be made for rescheduling an appointment, provided early notice of at least 2 business days are given. Otherwise a minimum charge of \$50 per hour may be incurred. We reserve the right to not reschedule your appointment.