ALLEGANY
DENTAL CARE

PATIENT REGISTRATION

Welcome to the Offices of Allegany Dental Care!
Drs. Alfred E. Smith, Edward R. Beachley, David C. Grimm
Thomas P. McCafferty, Benjamin J. Boniface, and Associates
www.alleganydentalcare.com
Please complete all parts for our records. This information is kept strictly **confidential**.

GETTING TO KNOW YOU

FULL NAME		TODAY'S DATE	
STREET ADDRESS		BIRTHDATE	AGE
CITY STATE ZIP CODE		IF CHILD, SCHOOL	GRADE
HOME PHONE INCL. AREA CODE	DAYTIME/WORK PHONE INCL. AREA CODE	MAY WE CONTACT YOU AT WORK? YES NO	
CELL PHONE INCL. AREA CODE	E-MAIL ADDRESS	MAY WE CONFIRM YOUR APPOINTMENT BY TEXT MESSAGE: YES NO E-MAIL: YES NO	
SOCIAL SECURITY NO.	DRIVER'S LICENSE NO. & STATE	SINGLE_____ MARRIED_____ DIVORCED_____ OTHER_____	
EMPLOYER NAME & ADDRESS		PHONE NO.	
OCCUPATION		HOW DID YOU FIND OUT ABOUT OUR PRACTICE?	
OTHER MEMBERS OF YOUR FAMILY, FRIENDS, OR RELATIVES WHO ARE PATIENT AT OUR OFFICE		WHO MAY WE THANK FOR REFERRING YOU?	
NAME, ADDRESS AND PHONE NO. OF PERSON TO CONTACT FOR EMERGENCY			
YOUR PHYSICIAN AND PHONE NUMBER			
IS THERE ANYTHING YOU WOULD LIKE US TO KNOW THAT WOULD ENABLE US TO TREAT YOU MORE EFFECTIVELY?			
NAME AND ADDRESS OF PREVIOUS DENTIST			
REASON FOR LEAVING PREVIOUS DENTIST			

ACCOUNT INFORMATION
PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT

NAME	RELATIONSHIP TO YOU	OCCUPATION	BIRTH DATE
ADDRESS IF DIFFERENT FROM ABOVE		DRIVER'S LICENSE NO. & STATE	
EMPLOYER'S NAME	ADDRESS		PHONE NO.
SOCIAL SECURITY NO.	HOME PHONE NO.	CELL PHONE NO.	

Please continue on the other side >>>

DENTAL INSURANCE

PRIMARY CARRIER		SECONDARY CARRIER	
INSURANCE COMPANY	TELEPHONE #	INSURANCE COMPANY	TELEPHONE #
EMPLOYEE (SUBSCRIBER) NAME	SUBSCRIBER TEL #	EMPLOYEE (SUBSCRIBER) NAME	SUBSCRIBER TEL #
GROUP OR EMPLOYER NAME	GROUP NUMBER	GROUP OR EMPLOYER NAME	GROUP NUMBER
SUBSCRIBER SOCIAL SECURITY NO.	DATE EMPLOYED	SUBSCRIBER SOCIAL SECURITY NO.	DATE EMPLOYED
SUBSCRIBER DATE OF BIRTH	ALTERNATE INSURANCE ID	SUBSCRIBER DATE OF BIRTH	ALTERNATE INSURANCE ID

FINANCIAL POLICY

1. We are committed to provide you with the best possible care, and will be happy to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship.

2. We constantly work to keep our fees reasonable, while providing our patients with the high quality of care they deserve.

3. PAYMENT is due on the date of treatment unless specific arrangements have been made.

4. INSURANCE is a contract between you and your insurance company. Therefore, it is your responsibility to understand the limits of your policy, the deductibles, and the types of services covered. Deductibles and co-pays will be collected on the date of treatment. We will bill your insurance at no charge as a courtesy to you. If a claim has not been paid within 45 days, we will bill you directly.

5. PAYMENT OPTIONS: Personal check, cash, VISA, MasterCard, American Express, Discover and Third Party extended Financing programs.

FINANCIAL AGREEMENT

I understand that responsibility for payment for Dental Services provided by **Allegany Dental Care, P.A.** for myself or my dependents is mine, due and payable at the time services are rendered unless specific financial arrangements have been made.

I also understand that any dental insurance I have is a contract between myself and my insurance carrier. **Allegany Dental Care, P.A.** is not responsible for my insurance carrier's action on my claim, and I understand that I have the final responsibility for payment of dental services.

I further understand that a 1½% late fee (18% annually) will be added to any balance over 60 days.

In the event of default (non-payment), I (we) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this debt.

Patient_____ Date_____ Witness _____

Parent or Responsible Party _____ Relationship to Patient_____
Please Print

Signature of Parent/Party _____