REGISTRATION FORM/ PATIENT INFORMATION

Patient: First Name ________________________ Last Name ____________________________________ Middle initial _____

Email _____________________________ I would like to receive correspondence via e-mail: Y N

DOB ______________________ Cell # _____________________________

Address ____

City _______________________________________ ____________________State ______ Zip Code ______________________

Home # ____ Work # ____

RESPONSIBILITY PARTY (IF SOMEONE OTHER THAN PATIENT) Name: _____________________________________

DOB ____ SSN # ____

Driver's license # ___________________________________ ____

PRIMARY INSURANCE INFORMATION

Name of Insured ____ Social Security # __________________________

Insured DOB _________________________Relationship to Insured : Self Spouse Child Other

Employer ____

Address: ____

City : ____ State _____________ Zip ___________

DO YOU HAVE SECONDARY INSURANCE INFORMATION ? YES NO Please provide information on reverse side

FINANCIAL POLICY

All emergency dental services or any dental services performed without previous financial arrangements must be paid for at the time services are rendered.

Out of network - Individuals who carry dental insurance understand that all dental services furnished are charged directly to the patient, and is personally responsible for payment of all dental services provided, regardless of dental insurance reimbursement. As a courtesy, this office will help prepare and submit patients' insurance forms as well as assist in making collections from insurance companies. We will credit such collections to the appropriate account. However , this dental office cannot render services on the assumption that our charges will be paid in part or in full by an insurance company.

In network - It is your responsibility to pay any deductible amount, co – insurance or any other balance not paid by your insurance company.

I further acknowledge that a proposed treatment plan can shift and /or change from the diagnosed treatment plan once treatment has begun due to unforeseen circumstances beyond Dr. Ivan's control.

Signature of Patient: (Parent or Guardian if minor) X ____

HIPPA

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

This signature on file is my authorization for the release of information necessary to process my insurance claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

I authorize the release of any information acquired in the course of my examination and treatment to other medical and/or dental professionals.

Signature of patient: (Parent or Guardian if minor) **X** ____