PATIENT REGISTRATION

Patient Information:

First Name: _____ Last Name: _____

Birth Date: _____ Preferred Name: _____

Address: _____

City: _____ State, Zip: _____

Home Phone: _____ Cell Phone: _____

☐ I would like to receive text correspondence

E-mail: _____

☐ I would like to receive email correspondence

Emergency Contact: _____ Relationship: _____

Phone: _____

Responsible Party: (if someone other than the patient)

Name: _____ Birth date: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Insurance Information:

Policy Holder: _____ Birth Date: _____

Employer: _____ Soc Sec/ID #: _____

Ins Company: _____ Payor ID #: _____

Address: _____ Phone: _____

PATIENT ACKNOWLEDGEMENT: I have read and completed the information on my Patient Registration as completely and accurately as possible. If I have any changes in my medical status or there are any changes in medications, I shall inform Grand Strand Family & Esthetic Dentistry at my next appointment. I agree not to hold my dentist, or any member of the staff, responsible for any error or omissions that I have made in completion of this form.

FINANCIAL and BILLING information: Payment at the time of services is requested unless prior arrangements have been made with our business office. I understand that I am responsible for payment in full for the costs of dental services provided to me. Any unpaid balances after 60 days are subject to a monthly service fee.
We ask that you provide us with 24 hours' notice of cancelation for any appointments. We reserve the right to charge for any appointments that are missed without notice. A fee of $75 may be charged for missed regular appointments, $150 for missed crown and bridge appointments.

HIPAA: I give consent to my doctor or designated staff's use and disclosure of any oral, internet or electronic health records that are identifiable as mine for the purpose of carrying out my treatment, payment and healthcare operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining my protection and Grand Strand Family & Esthetic Dentistry's HIPAA policy is available to me.

PATIENTS with DENTAL INSURANCE: You are personally responsible for all services provided by our dentist. We are glad to assist you by submitting to your dental insurance carrier on your behalf. However, it is your responsibility to know what type of insurance you have and the type of coverage it provides. Please note that treatment is based upon individual needs, which may or may not be covered by your insurance. To file to your dental insurance carrier, all policy information is needed at the time that care is provided. **Portions estimated to be uncovered by insurance are requested at the time services are rendered and any unpaid portions are due in full within 60 days by patient**. Your signature on this form authorizes Grand Strand Family & Esthetic Dentistry to release all information necessary, manually or electronically, to secure payment.

Patient's Signature: _____ Date: _____

Parent/Responsible Party: _____ Relationship to Patient: _____

How did you hear about us? _____