# WELCOME

## PATIENT REGISTRATION INFORMATION

LAST NAME _____ FIRST _____ M. _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

HOME PHONE _____ CELL _____ EMAIL _____

PATIENT BIRTH DATE _____ AGE _____ MALE _____ FEMALE _____

MARRIED _____ SINGLE _____ DIVORCED _____ WIDOWED _____

PATIENT SOCIAL SECURITY _____

PATIENT EMPLOYMENT _____

ADDRESS _____ WORK PHONE _____

EMERGENCY CONTACT _____ PHONE # _____

RELATIONSHIP TO PATIENT _____

PARENTS NAME (IF ABOVE IS A CHILD) _____

SOCIAL SECURITY MOTHER _____ FATHER _____

PARENT EMPLOYMENT _____

ADDRESS _____ WORK PHONE _____

DENTAL INSURANCE COMPANY _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

INS. CO. PHONE _____ GROUP # _____

SUBSCRIBER NAME _____ SUBSCRIBER BIRTHDATE _____

SUBSCRIBER ID# OR SS# _____

COVERAGE SELF _____ SPOUSE _____ FAMILY _____

YOU WERE REFERRED TO OUR OFFICE BY _____

**(Please Complete Other Side)**

## FINANCIAL POLICY

1. **Payment** by cash, check or credit card is required at the time service is provided. A 5% discount is given for payment by cash or check.

2. **Insured Patients:** We are insurance providers for Delta Premier, Delta PPO, Medica Commercial, Medica for Seniors, Health Partners and Cigna. However, we will assist in filing all claims. It is the patient's responsibility to understand the benefits and limitations of the dental insurance plan. If payment has already been made on day of treatment, insurance benefits will be sent directly to you.

3. **Other payment options:** For flexible monthly payment plans we offer Care Credit and financial arrangements with Lakes State Bank to help make your dental treatment more affordable. Please inquire.

## CONSENT FOR TREATMENT

1. I hereby authorize Dr. Lewis or designated staff to take x-rays, study models, photographs and other diagnostic aids necessary to make a thorough diagnosis and treatment plan.

2. I authorize Dr. Lewis to perform all recommended treatment **mutually agreed upon**.

3. I agree to the use of anesthetics, sedatives, and other medications as necessary. I fully understand that using anesthetic agents embodies certain risks.

4. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service . In the event payments are not received by agreed upon dates, I understand that an 18% APR will be added to my account. If required, I also understand a check of my credit history may be made.

Patient's Signature _____Date_____

Parent/Responsible Party Signature_____Relationship to Patient _____

We Appreciate The Opportunity To Serve You.