DATE ____________________

PATIENT'S NAME ____
LAST FIRST MI

DATE OF BIRTH ____________________ SSN # ____________________

ADDRESS ____

CITY ______________________ STATE __________ ZIP _____________

HOME PHONE # ____________________

MOBILE # _________

OTHER # _________

E-MAIL ADDRESS ____

WHOM MAY WE THANK FOR THIS REFERRAL? ____________________

____

SOMEONE TO NOTIFY IN CASE OF EMERGENCY __________________

____

DO YOU HAVE DENTAL INSURANCE? ☐ YES ☐ NO

NAME OF INSURANCE COMPANY ______________________________

PHONE ____________________________ GROUP # ________________

EMPLOYER ____

POLICY HOLDER ____

DATE OF BIRTH ____________________ SSN # ____________________

PLEASE LIST ANY OTHER FAMILY MEMBERS ____________________

____

FOR OFFICE USE ONLY

DATE OF INQUIRY __________________ CONTACT NAME

INSURANCE COMPANY

ADDRESS

CITY ____________________ STATE ____________ ZIP

PHONE

EFFECTIVE DATE _______________ GROUP#

ANNUAL MAXIMUM $ __________________ CALENDAR OR FISCAL

DEDUCTIBLE $ ________________ WAIVED FOR PREVENTATIVE? Y N

PREVENTATIVE _____% BASIC ______% MAJOR ______%
ORTHO ______ %

ORTHO Y N ORTHO MAX $ __________ ORTHO DED. $

ORTHO COVERAGE FOR ADULTS? Y N ORTHO DEP AGE THRU

POST. COMP. COVERED? Y N MISSING TOOTH CLAUSE? Y N

WAITING PERIOD FOR MAJOR? Y N

IMPLANT (6010)? Y N IMPLANT CROWN (6066)? Y N

DEBRIDEMENT(4355)? Y N PERIO MAINT. (4910)? Y N INTERVAL

PROPHY INTERVAL _______________ EXAM INTERVAL

BWX INTERVAL ______________ FMX/PANO INTERVAL

FLOURIDE? Y N UP TO AGE? _______ FLOURIDE INTERVAL

SEALANTS? Y N SEALANTS INTERVAL?

WHICH TEETH? ______________ UP TO AGE?

I authorize Dr. Bashi to diagnose and perform treatment procedures that may be necessary for proper dental care. I authorize the release of any information concerning my (or my child's) dental care for the purpose of evaluating and administering claims for insurance benefits.

I understand I am financially responsible for payments, in full, of all accounts, whether I have dental insurance or not. I understand that my insurance provider may pay less than estimated by our office. I understand that there will be a finance charge of 1.5% per month on any outstanding balance over 30 days. I understand that a total of 3 statement reminders will be sent to me. I understand that if my account is not paid within 90 days (unless waiting on insurance payments) there will be collection procedures including all attorney fees and additional of 40% of the balanced owed.

I understand that there WILL be a charge of $75 applied to my account for canceling or breaking an appointment without 24 hours notice. I understand there WILL be a charge of $300 applied to my account for implants, crowns and root canals if broken or not canceled within 48 hours notice.

PATIENT'S (IF MINOR - PARENT/GUARDIAN'S) SIGNATURE ____ DATE ________________

REGISTRATION