Patient Registration

Holmes FAMILY & COSMETIC DENTISTRY
10435 Illinois Road, Fort Wayne, IN 46814
Ph: (260)469-3671 | www.holmesfamilydentistry.com

Patient Name:_____ Gender: ○ M ○ F Birth Date:_____ Today's Date:_____ Age:_____

Home Address:_____ City:_____ State:_____ Zip:_____

Email Address:_____ Cell Phone:_____ Home Phone:_____

Social Sec. #:_____ Please Check One: ○ Single ○ Married ○ Separated ○ Widowed

Work Phone:_____ Your Employer:_____ Occupation:_____

Person Responsible for Account:_____ Parent if Patient is a Minor:_____

How did you hear about our office?_____ Reason for Visit:_____

EMERGENCY INFORMATION *(A relative not living with you)*

Name:_____ Address:_____ Telephone:_____

DENTAL INSURANCE INFORMATION (Primary Carrier)

Insured's Name:	DOB:	SS#:
Insured's Employer:	Insurance Co.:	
Phone Number:	Group Number:	Local #:

Do you have Secondary Dental Insurance?

○ Yes ○ No

Financial Policy

Thank you for choosing our office as your dental health care provider. We are committed to providing you with the highest quality dental care, so that you may fully attain optimum oral health. Please understand that payment of your bill is considered part of your treatment. Payment is due at the time service is provided. We ask that you pay the deductible and co-payment, which is the estimated amount not covered by your insurance company. Our office accepts cash, all major credit cards, and outside financing information is available upon request. Please Note: Returned checks will be subject to additional fees. In the case it becomes necessary for our office to enlist a collection service and/or legal assistance, you will be responsible for any collection and/or legal charges incurred up to 35%.

Do You Have Insurance?

- As a courtesy to you we will help you process all your insurance claims. Please understand that we will provide an insurance estimate to you, however it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits ultimately determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible.
- All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company. Our office is not a party to that contract.
- Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.
- We ask that you sign this form and/or any other necessary-documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office.
- Insurance payments are ordinarily received within 30-60 days from the time of filing. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.
- We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not however, enter into a dispute with your insurance company over any claim.

We thank you for the opportunity to serve your dental health care needs and welcome questions you may have concerning your care or our financial policy.

CONSENT

I have read, understand and agree to the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to my dental office.

The undersigned, hereby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a finance, rebilling, collection charge or attorney fee will be added to any overdue balance.

_____ _____

Patient's Signature (Parent of Child) Date

SUBMIT