Stanley F. Kayes, DDS

PATIENT REGISTRATION FORM

Name_____ Date of Birth_____

Address_____City/State/Zip_____

Social Security Number_____

Employer_____ Occupation_____

Spouse's Name_____ Spouse's Employer_____

Your physician(s)_____ Telephone_____
Person to Contact
In an Emergency_____ Telephone_____

How did you find out about this office? _____

_____

COMMUNICATION INFORMATION (answer any that apply)

Home Phone_____ Work Phone_____ Pager_____

Cell Phone_____ E mail_____ Fax _____

What is the best way to reach you in the daytime?_____
What is the best way to reach you in the evening?_____

List any special instructions in getting messages to you:_____

_____
(please include any different sleeping schedules due to shift work, best times to call, etc.)

Please authorize below any ways that we may leave messages regarding your dental treatment or account or insurance information. Answer yes or no for all that apply.
On your home answering machine _____ By E mail_____
With your spouse_____ On your office voice mail _____
With a designated relative or friend (please list)_____
By designated fax number_____

_____

INSURANCE INFORMATION

Name of Insured_____ Insured's Birthdate_____
Employee
Ins.Company_____ Group #_____ Certificate #_____

Insurance Address_____Phone_____

Secondary Dental Insurance Information
Name of Insured_____ Insured's Birthdate_____
Employee
Ins. Company_____Group #_____ Certificate #_____

Insurance Address_____Phone_____

INSURANCE AUTHORIZATION AND RELEASE

I authorize the dentist to release information and records of any treatment rendered to me to my insurance company or to other health care providers, including my physician, any specialists to whom I am referred, laboratories, or hospitals _____(initial)

I authorize my insurance company to pay directly to the dentist insurance benefits otherwise payable to me _____ (initial)

I understand that my dental insurance may pay less than the actual bill for service and that this office does not guarantee any payment from my insurance company. I understand that it is my responsibility to know my insurance company's regulations regarding the timing of my dental exam, x-rays, and cleaning appointments, and their rules regarding substitution of alternative dental treatments. I agree that I am responsible for payment to this office for any amount not covered by insurance_____(initial)

Signature_____ Date_____

For young adults/students over age 18 with parents responsible for account:

You may discuss my treatment with my parents_____

Person responsible for payment of my account_____ If parents are responsible at least in part for payment, please sign to authorize discussion of the account with them.

Signature_____ Date_____

FINANCIAL POLICY/ CANCELLATION POLICY
All checks returned by the bank are subject to a fee of $20.00.

Accounts that are delinquent over thirty days will incur a service charge of 1% per month (12% annual percentage rate).

In case of default of account for present and future balances, patient or person responsible for account agrees to pay collection costs, including attorney's fees, incurred in attempt to collect balance due.

Appointment cancellations and no shows: We will attempt to contact you to confirm your dental appointments. If you can not be contacted after several attempts to confirm appointment, your appointment time may be released to another patient on a waiting list. If after appointment confirmation is made, you do not show for the appointment or cancel with less than twenty- four hours notice, a cancellation fee may be assessed.

I understand the financial and cancellation policies at this office. I understand that I am responsible for all services rendered to me. If another person is responsible for this account, or if responsible party changes, I understand that it is my responsibility to notify this office.

Signature_____ Date_____