

# REGISTRATION FORM

DATE: \_\_\_\_\_

NAME (LAST) \_\_\_\_\_ (FIRST) \_\_\_\_\_ (MI) \_\_\_\_\_

PERSON RESPONSIBLE FOR PAYMENT: (FULL NAME) \_\_\_\_\_

HAVE WE SEEN ANY OTHER FAMILY MEMBERS BEFORE? (HIS/HER NAME) \_\_\_\_\_

## **PATIENT INFORMATION:**

ADDRESS \_\_\_\_\_

SPOUSE/PARENT NAME \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

ADDRESS (IF DIFFERENT) \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

CELL \_\_\_\_\_ (H) \_\_\_\_\_ (W) \_\_\_\_\_

CELL \_\_\_\_\_ (H) \_\_\_\_\_ (W) \_\_\_\_\_

E-MAIL \_\_\_\_\_

E-MAIL \_\_\_\_\_

SEX \_\_\_\_\_ BIRTH DATE (MM) \_\_\_\_\_ (DD) \_\_\_\_\_ (YY) \_\_\_\_\_

SEX \_\_\_\_\_ BIRTH DATE (MM) \_\_\_\_\_ (DD) \_\_\_\_\_ (YY) \_\_\_\_\_

SOCIAL SECURITY # \_\_\_\_\_

SOCIAL SECURITY # \_\_\_\_\_

EMPLOYER \_\_\_\_\_

EMPLOYER \_\_\_\_\_

ADDRESS \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

## **HOW DID YOU FIND OUR OFFICE?**

Yellow Pages     Insurance Company     Website     Friend/Relative, If so Name \_\_\_\_\_

## **FAMILY MEMBER(S): (IF DIFFERENT LAST NAME, PLEASE SPECIFY)**

NAME	BIRTH DATE: (MM/DD/YY)
#1. _____	_____
#2. _____	_____
#3. _____	_____
#4. _____	_____

## **INSURANCE POLICY INFORMATION:**

PRIMARY INSURANCE \_\_\_\_\_

POLICY HOLDERS NAME \_\_\_\_\_

POLICY HOLDERS ID# \_\_\_\_\_

RELATIONSHIP TO PATIENT \_\_\_\_\_

POLICY HOLDERS SS # \_\_\_\_\_

BIRTH DATE (MM/DD/YY) \_\_\_\_\_

INSURANCE ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

INSURANCE TELEPHONE \_\_\_\_\_

EMPLOYER \_\_\_\_\_

SECONDARY INSURANCE \_\_\_\_\_

POLICY HOLDERS NAME \_\_\_\_\_

POLICY HOLDERS ID# \_\_\_\_\_

RELATIONSHIP TO PATIENT \_\_\_\_\_

POLICY HOLDERS SS # \_\_\_\_\_

BIRTH DATE (MM/DD/YY) \_\_\_\_\_

INSURANCE ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

INSURANCE TELEPHONE \_\_\_\_\_

EMPLOYER \_\_\_\_\_

## **ASSIGNMENT OF DENTAL BENEFITS**

I HEREBY AUTHORIZE PAYMENT OF GROUP DENTAL BENEFITS, OTHERWISE PAYABLE TO ME, TO THE NAMED PROVIDER FOR PROFESSIONAL SERVICES RENDERED.

SIGNED (PATIENT/RESPONSIBLE PARTY) \_\_\_\_\_ DATE \_\_\_\_\_

*\*I have provided the office with the most current insurance information and am responsible for updating any changes and/or additions.*

## FINANCIAL POLICIES/AUTHORIZATIONS

**Your Insurance benefits:** Insurance is a contract between you and your insurance company. Please review your policy. Many insurances have clauses and limitations. It is your responsibility to verify coverage and benefits with your insurance company prior to the time services are rendered by our office. Our office may assist you in identifying your dental benefits, but the ultimate decision is made by your insurance company on whether services are a covered benefit and how much to pay if anything. We will collect an estimated co-pay at the time of service, however that information may not be accurate or current on the date the services are actually performed. **We can not authorize treatment nor guarantee eligibility, benefits or payment from your carrier.** You agree to pay any balance not paid by your insurance company.

\*\*As a courtesy, our office may submit insurance claims on your behalf, but by signing below you agree it is your responsibility to make sure all filings are made timely and completely and to follow up with your insurance company. If your insurance company notifies you that it requires additional information from either our office, or you, to process your claims, or if you discover any problem or denial of benefits that requires additional information from our office, you agree to notify our office in writing within two (2) weeks of your receipt of such information. You agree that the request for additional information from our office does not in any way make our office liable for any decision regarding your insurance coverage or benefits. You agree that our office shall not be liable for any errors or omissions in filing claims on behalf of you, or your family. Any insurance reimbursement that you receive that is otherwise due to the office must be reported and paid immediately to the office in order to receive any insurance contractual fees. **Claims that are not paid by your insurance within ninety (90) days of filing will be billed to the responsible party.**

**Payments:** Payment is expected at the time of service. Time of service is defined as the time services are initiated. You may pay by cash, check or credit card. For your convenience we accept Master Card, Visa, American Express, Discover and Care Credit. There is a fee for any returned checks.

**Missed appointments:** We will attempt to make a courtesy call as a reminder for an appointment. However, if you do not receive one, it does not change your responsibility to keep your appointment. Patients who do not show up for an appointment, or cancel with less than 24 hours notice will be charged a fee. This fee will be determined based on length of time and procedure reserved for the patient. This fee must be paid before a new appointment is scheduled. Patients with three (3) missed appointments may be asked to transfer their records to a new provider.

**Transferring records:** You will need to request in writing, and pay a reasonable administrative fee, if you want to have copies of your records sent to another doctor or organization. You authorize us to include any relevant information, including your payment history. If you are requesting your records to be transferred from another doctor or organization to us, you authorize us to receive all written relevant information.

**Use and disclosure of protected health information:** Howard Hoffman, D.D.S., Ltd. may use and disclose your protected health information for purposes of treatment, payment and health care operations. You acknowledge that you have received, have been offered or have received in the past a copy of the Practices Notice of Privacy Practices explaining such disclosure. In addition, you agree not to post or publish any comments, remarks or statements, electronically or otherwise, that are disparaging, or in anyway related to any treatment at the Hoffman Dental Group.

**Account information:** Patient hereby certifies that all information is correct and that the patient has an obligation to keep this information current. **Any changes in the patient's address, contact information or dental insurance must be submitted in writing to the office immediately.** I, (PATIENT OR RESPONSIBLE PARTY) AGREE THAT HEALTH AND ACCIDENTAL INSURANCE POLICIES ARE AN ARRANGEMENT BETWEEN AN INSURANCE COMPANY AND MYSELF AND THAT ALL SERVICES RENDERED TO ME AND ANY OTHER CHARGES ON MY ACCOUNT ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT. I AGREE TO PAY ACCOUNT BALANCE WITH HOWARD HOFFMAN, D.D.S., LTD. WITHIN FIVE(5) BUSINESS DAYS FROM RECEIPT OF MY BILL. HOWARD HOFFMAN, D.D.S., LTD., (HH D.D.S. LTD) MAY DELAY REQUESTING FULL PAYMENT AS A COURTESY WHILE WAITING FOR INSURANCE PROCEEDS OR ELECT TO SEND A BILL FOR SERVICES RATHER THAN COLLECTING PAYMENT AT THE TIME SERVICES ARE RENDERED, BUT HH D.D.S. LTD IS UNDER NO OBLIGATION TO DO SO. ANY AGREEMENTS FOR LESS THAN PAYMENT IN FULL AT THE TIME OF SERVICES MUST BE IN WRITING AND SIGNED BY THE OFFICE AND MYSELF IN ORDER TO BE ENFORCEABLE. IF HH D.D.S. LTD EXTENDS ME THE COURTESY OF A PAYMENT ARRANGEMENT, HH D.D.S. LTD MAY TERMINATE THAT ARRANGEMENT AT THE OFFICE'S SOLE OPTION AT ANY TIME WITHOUT NOTICE.

IN THE EVENT THAT THE BILL BECOMES PAST DUE FOR ANY REASON, HOWARD HOFFMAN, D.D.S., LTD., AND HIS ASSIGNEES, OR LAWFUL AGENTS MAY IMMEDIATELY CONSIDER THE ACCOUNT IN DEFAULT AND PURSUE COLLECTION PROCEDURES. I AGREE TO PAY 18% YEARLY INTEREST ON THE UNPAID BALANCE, AS WELL AS ALL COSTS OF COLLECTION. COLLECTION COSTS MAY INCLUDE, BUT ARE NOT LIMITED TO, COURT FILING FEES, SERVICE OR PROCESS COSTS, ATTORNEY FEES OF 40% AND ENFORCEMENT OF JUDGMENT EXPENSES.

THIS IS THE ENTIRE AGREEMENT OF THE PARTIES AND SUPERCEDES ANY PRIOR WRITTEN OR ORAL REPRESENTATIONS OR AGREEMENTS CONCERNING PAYMENT FOR SERVICES RENDERED.

I, (PATIENT OR RESPONSIBLE PARTY) HAVE READ AND AGREE TO THE TERMS ABOVE: \_\_\_\_\_

PRINTEDNAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_ DATE: \_\_\_\_\_