Pioneer Valley Dental Arts
Patient Registration

Patient:

Name: _____

[ ] Male [ ] Female Preferred name: _____

Address: _____

City/State/Zip: _____

Home Phone #: _____

Work Phone #: _____ Ext #: _____

Cell Phone #: _____

Email: _____

How would you like us to confirm your appointments?
[ ] Home phone [ ] Text Message [ ] Email

Employer: _____

Occupation: _____ How long: _____

Birthdate: _____/_____/_____ SS#: _____

Marital Status: [ ] Minor [ ] Single [ ] Married [ ] Widowed

[ ] Divorced [ ] Separated

Spouse's Name: _____

Do you have children? [ ] Yes [ ] No How many? _____

Referred by: _____

Person Responsible For Account:

Name: _____

Relationship: _____

SS#: _____ Birthdate: _____

Address: _____

City/State/Zip: _____

Home Phone #: _____

Work Phone #: _____

Employer: _____

Primary Dental Insurance:

Ins Co. Name:_____

Address: _____

City/State/Zip: _____

Phone #: _____

Insured's Name:_____

Address: _____

City/State/Zip: _____

Insured's Employer: _____

Group #: _____Insured's ID #: _____

Birthdate: _____/_____/_____Relationship:_____

Secondary Dental Insurance:

Ins Co. Name:

Address: _____

City/State/Zip: _____

Phone #: _____

Insured's Name: _____

Address: _____

City/State/Zip: _____

Insured's Employer: _____

Group #: _____ Insured's ID #: _____

Birthdate: ____/____/_____ Relationship: _____

Emergency Contact: (not residing at the same address as the patient)

Name: _____

Relationship: _____

Phone #: _____

Authorization

Name of Patient: _____

I, the undersigned, hereby authorize payment of dental benefits, if any, directly to the Doctors. Payment or copayment is expected at the time services are rendered by cash, check, Mastercard, Visa, Discover or CareCredit unless other arrangements have been made with the treatment coordinator **prior** to services being rendered.

Dental Insurance: Regardless of the type of insurance coverage you have, the full amount of your account is the patient's or the guardian's responsibility. Your insurance claims are processed by our office, as a courtesy, at no charge. However, the contract is between the patient and the insurance company. Please notify the office promptly of any change in employment or insurance carrier.

Divorced and Separated Parents: The parent accompanying the patient to the visit is responsible for payment of the account.

All accounts 60 days past due and over will accumulate a finance charge of 1.5% per month or 18% annually.

I hereby agree that I, the undersigned, shall be liable for any reasonable attorney's and court fees and/or collection costs incurred by the Doctors in the event that such bills are placed with an attorney or third party.

I hereby authorize medical/dental surgical treatment, care and/or services by the Doctor to the above named patient.

I hereby authorize the Doctors to release any information acquired in the course of examination or treatment, **with my knowledge and consent**.

I hereby authorize any physician, health care practitioner, hospital or medical care facility to provide all information on the above named patient's medical history to the Doctors.

Twenty-four hour notice must be given if you cannot keep an appointment, otherwise a charge will be assessed.

I hereby authorize photocopies of this form to be valid as the original.

Signature: _____ Date: _____/_____/_____

Print Name: _____ Relationship to Patient: _____

If a patient is under 18 years of age, a parent or guardian must sign.