College Avenue Dental
Registration Form

PATIENT INFORMATION

Today's Date_____

Patient's Last Name_____ First_____ M.I._____ Mr.___ Mrs.___ Miss___ Ms.__

Sex: M__ F__ Birth Date ____ /____ /____ Married ___Single___ Social Security #_____- ___-_____

Address_____City_____State_____Zip code_____

Phone #: Home_____ Cell_____ Email Address_____

Employer _____ Occupation _____

Employer Address _____ Phone no. _____

Person responsible for bill_____ Relationship to patient_____

Address and Phone # (if different from above)_____ _____

In case of emergency contact_____Relationship_____Phone #"s_____

DENTAL INSURANCE

Insurance Company Name_____ Subscriber's Name _____

Subscriber's SS#_____-___-_____ Birth Date___/___/___ Group #_____ Policy #_____

Employer Name, Address & Phone# (if different from above) _____

How did you learn about College Avenue Dental?_____

INSURANCE ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with the above named insurance and assign directly to Dr. Randall E. Lawson all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize use of my signature on all insurance submissions. The above-named doctor may use my, and/or my dependants, health care information and may disclose such information to the above-named Insurance company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

DEPENDENT CONSENT

I am the parent, guardian or personal representative of the above named patient and there are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize the dental staff to perform necessary dental services for the dependent named above, including but not limited to x-rays, and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present when the treatment is rendered.

FINANCIAL AGREEMENT

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that I am responsible for all fees and services rendered for treatment; this includes a $35 fee if any check is returned for non-sufficient funds. I accept full financial responsibility for all charges for services or items provided to me or the patient. I understand that filing a claim with my insurance company does not relieve me from my responsibility for the payment of all charges. A service charge of 1.5% per month (18% per annum) on the unpaid balance will be assessed monthly after the original thirty day payment period until your account is referred to collection, unless previously written financial arrangements are agreed upon. I further agree to pay all costs and collection cost of 35% of the balance, court cost and attorney fees that result from not maintaining my account.

PAYMENT ALTERNATIVES

---- Cash and personal checks are accepted as our payments.
---- MasterCard, Visa, Discover and American Express.
---- For long term or extended payments, we offer a healthcare financing program, which once you are extended a line of credit will allow small monthly payments for the treatment received.
---- If you have dental insurance, we want you to receive the full benefit of it. Our office team can assist you in completing your insurance forms and verifying the coverage that you particular program provides. We accept assignment of your insurance payment, another service to you. This means that you are responsible for your deductible and the portion the insurance does not cover. Remember, however, that you are responsible for the account if the insurance company, for any reason, does not honor their commitment to you and to us.

CERTIFICATION

To the best of my knowledge, the information provided on this form is complete and correct. I understand that it is my responsibility to inform my doctor if I and/or my dependent ever have a change in health. I have read, understand and accepted the above conditions of treatment and payment. I certify that I am the patient, or am duly authorized on behalf of the patient to execute such an agreement.

_____

Signature of Patient, Parent, Guardian or Personal Representative Date

_____

Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

PLEASE COMPLETE OTHER SIDE…