SILVER CREEK DENTAL & VISION CARE **DENTAL REGISTRATION**

PATIENT INFORMATION

Patient (Last, First Middle) _____

Birth date (mm-dd-yyyy) _____ Gender (male / female) _____

Home address _____

City, State, Zip _____

I wish to be contacted at cellular phone ☐, home phone ☐ E-mail ☐

by leaving a detailed message ☐ and or callback number only ☐.

Cellular phone # _____ Home phone # _____

E-mail address _____

FINANCIAL AGREEMENT

I certify that I (or my dependent) have dental coverage with an insurance company and assign directly to this clinic all insurance benefits for services rendered. I hereby authorize the clinic to release my information and signature necessary to secure the payment of benefits.

This clinic's staff would assist me in estimating the insurance benefits, which are never guaranteed. I am responsible for payment of deductibles, non-covered procedures and co-pays at the time of service, and insurance claims remaining unpaid after 8 weeks. I am responsible to bill the secondary dental insurance.

There is a $50 fee for any returned check.

SCHEDULING AGREEMENT

I agree to reschedule my appointment 48 hours in advance or to pay $50 broken appointment fee per scheduled hour. I understand that 3 broken or rescheduled appointments will result in termination of my dental care at this clinic.

LIMITED SERVICE AGREEMENT FOR WA Medicaid PATIENTS

I agree to limited dental services at this private clinic and seek additional care somewhere else for my comprehensive dental needs.

PRIVACY PRACTICES ACKNOWLEDGEMENT

I reviewed the Notice of Privacy Practices. And I authorize to disclose my dental information listed here

_____

to the following persons/organizations and for purposes not listed in the Notice, effective immediately until further notice:

Name _____ relationship _____

Patient or guardian signature _____ Date _____

Guardian name & relationship _____