PATIENT REGISTRATION

LAST NAME: _____ FIRST NAME: _____ MI: _____

ADDRESS: _____

CITY, STATE, ZIP: _____

PHONE: (____) _____-_____ SECONDARY PHONE: (____) _____-_____

DOB: _____/_____/_____ EMPLOYER: _____

BILLING

PERSON RESPONSIBLE FOR BILL (*ONLY COMPLETE IF DIFFERENT FROM PATIENT*)

RELATIONSHIP TO PATIENT: (CHECK ONE): ( ) SELF ( ) SPOUSE ( ) PARENT

NAME: _____DOB: _____/_____/_____

SOCIAL SECURITY #: _____ - _____ - _____ PHONE: (____) _____-_____

ADDRESS: _____

LIST ANY DEPENDANTS:

NAME	DOB	RELATIONSHIP

TOTAL DUE $_____

METHOD OF PAYMENT (CHECK ONE): ( ) CASH ( ) CHECK ( ) CREDIT/DEBIT CARD

( ) MASTERCARD ( ) VISA ( ) AMERICAN EXPRESS ( ) DISCOVER

CREDIT/DEBIT CARD #: _____ EXP: _____

SIGNATURE:_____

PLEASE READ DISCLAIMER AND SIGN BELOW:

Using Quality Dental Plan (QDP), our office offers significant savings to patients in regards to dental services. Furthermore, I understand the benefits, limitations, exclusions, and requirements of this plan and agree to the following:

- Fees for dental services are due when rendered; and
- Fees for prosthodontic (dentures) and cast restorations (crowns, in-lays, on-lays, veneers) are due at the preparation/impression visit.

If I, _____ choose not to pay at the time of service or not have a financial arrangement in place, I shall be billed the customary fees for such services. I acknowledge that I am financially responsible for payment.

SIGNATURE: _____ DATE: _____