PATIENT REGISTRATION

PATIENT INFORMATION

PATIENT'S NAME Last ________________ First ________________ Middle Initial ________ Preferred Name: ________________

Soc. Sec. # ________________ SEX: ______ BIRTHDATE ________________ AGE ______ FT Student: Y N If yes, Where: ________________

Whom May We Thank for Referring You to our Office? ________________

RESIDENCE Street ________________ Apt # ________ City ________________ State ________ Zip ________________

If Different from Above:

MAILING ADDRESS Street ________________ Apt # ________ City ________________ State ________ Zip ________________

HOME PHONE ________________ CELL PHONE ________________ WORK PHONE________________

EMAIL ________________ May we Text you Appointment Reminders: ______ YES _______ NO

SOCIAL SECURITY # ________________ BIRTHDATE ________________ DRIVER'S LICENSE # ________________ RELATION TO PATIENT________________

EMPLOYER ________________ Phone Number________________ .

CANCELLATION POLICY

We aim to provide our clients the highest quality service and pride ourselves on our exceptional team. If you should cancel or reschedule your reserved appointment less than 24 hours before your schedule appointment time, we not only lose your business, but also the potential business of other clients who may have taken your scheduled time. For this reason we are obligated to compensate our team for their time and well as make up for lost revenue. After 2 occurrences, we will require you to pay a $100 deposit to schedule another appointment. This $100 will be applied to your treatment the day of the scheduled appointment. Patients who no show an appointment will be charged $50.00

Please initial that you have read and understand the policy ____________

EMERGENCY INFORMATION: RELATIVE NOT LIVING WITH YOU.

NAME ________________

RELATIONSHIP________________

HOME PH. ________________ CELL PH. ________________

WORK PH. ________________

DENTAL INSURANCE INFORMATION (Primary Carrier)

Insured's Name ________________

Insurance Co. ________________ E-MAIL ________________

Insurance Co.Phone ________________

Insured's Employer ________________

Insured's Date of Birth ________________

Insured's Soc. Sec. # ________________ Group # ________ ID#__________

If you have secondary dental insurance coverage, complete this for the second coverage.

Insured's Name ________________

Insurance Co. ________________ E-MAIL ________________

Insurance Co. Address ________________

Insured's Employer ________________

Insured's Soc. Sec. # ________________ Group # ________ ID # ____________

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance cover with the above named insurance company and assign directly to Dr. Kelly West 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 the use of my signature on all insurance submissions. This assignment and release will apply to any new insurance provided to the office in the future

Dr. Kelly West may use my health care information and may disclose such information to the above-names insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. The Doctors also have my consent to use any photos taken.without identifying information or full face, for use in journals, office use, website, and other advertising.

PATIENT Signature (Parent of Child) ________________ Date: ________________ DENTIST Signature ________________