PATIENT REGISTRATION

Patient's Name:_____
FIRST LAST

Patient is: ___ Policy Holder
___ Responsible Party

Patient Information:

Mailing Address: _____

Physical Address: _____

City: _____ State: _____Zip:_____

Home Phone: _____ Work Phone: _____ Cell Phone:_____

Email: _____

Date of Birth: _____/_____/_____ Sex: M F

Social Security Number: _____ Drivers License:_____

Marital Status: _____ Married _____ Separated _____ Divorced _____ Widowed _____ Single
FRDC may contact me by: _____Phone _____Text _____ Email _____ Mail

Financial Responsibility:

I understand payment in full is expected as I am treated at Falcon Ridge Dental Care.

As a courtesy, FRDC will bill the insurance company and not require immediate payment for the amount we estimate the insurance will pay (the patient's co-payment percentage is required at the time of service). In this situation all service charges are waived for 60 day or until the payment is received from the insurance company. Any balances left after insurance payment (and/or 60 days without payment from insurance company) will become the responsibility of the patient/ guarantor. These balances will be subject to a service charge as defined below.

I understand that as the patient/ guarantor, I am responsible for payment for all services rendered by this practice. I further understand that all balances over 30 days, other than outstanding insurance payments as noted above, are subject to a 1.75% per month service charge.

If my account becomes delinquent (3 or more consecutive months without a payment), then I understand a collection agency will be retained to obtain payment. I agree to pay all attorney fees, court costs, filing fees, and collection costs, up to 50% in addition to the amount owed.

_____ _____
Patient/ Guarantor Signature Date

_____
Patient/Guarantor's Name Printed