CONFIDENTIAL

Patient Registration Information

Date ______________________

Name ____ Patient # ____________________
First Mi Last

Welcome to our practice!

Thank you for selecting our dental healthcare team. Please fill out this form completely in ink. If you have any questions or concerns, please do not hesitate to ask for assistance-we will be happy to help!

Home address ____________________ City ____________________ State/Prov. ________ Zip/P.C. __________

Birthdate ______________ Home Phone ____________________ Work Phone ____________________

E-Mail ____________________________________ Cell Phone ____________________________

Do you prefer to receive calls at: ☐ Work ☐ Home ☐ Either

Are you: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Your or your parent/guardian's employer ______________________ Occupation ____________________

Business address ____________________ City ______________ State/Prov. ____________ Zip/P.C. __________

Spouse or parent/guardian's name ____________ Employer ____________________ Work phone __________

If you are a student, name of school/college ______________ City ______________ State/Prov. __________

Whom may we thank for referring you? ____

Person to contact in case of an emergency ______________________________ Phone ______________

Responsible Party

Name of person responsible for this account ____________________ Relationship ____________________

Address ____ Home Phone ________________

City ____________________ State/Prov. ____________ Zip/P.C. __________ SS #/SIN ________________

Driver's license # ____________________ Birthdate __________ Financial institution ________________

E-Mail ____________________________________ Cell Phone ____________________________

Employer ____ Work phone ____________________

Is this person currently a patient in our office? ☐ Yes ☐ No

Insurance Information

Name of insured ____

Relationship to patient ____

Birthdate ________________ SS #/SIN ____________________ Date employed ________________

Employer ____ Work phone ____________________

Address of employer ____________________ City ______________ State/Prov. ____________ Zip/P.C. __________

Insurance company ____________________ Group # ______________ Employer/cert. # ______________

Ins. co. address ____________________ City ______________ State/Prov. ____________ Zip/P.C. __________

How much is your deductible? __________ How much have you used? __________ Max. annual benefit? __________

Please Continue... ☞

BROWNSBURG FAMILY DENTAL CARE
TODD R. EDER, D.D.S.

Acknowledgement of Receipt of Notice of Privacy Practices

* You May Refuse to Sign This Acknowledgement*

I, ______________________________, have received a copy of this office's Notice of Privacy Practices.

____
Please Print Name

____
Signature

____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

___ Individual refused to sign

___ Communication barriers prohibited obtaining the acknowledgement

___ An emergency situation prevented us from obtaining acknowledgement

___ Other (Please Specify)

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Dear Valued Patient:

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. The best way to save on dental costs is prevention plus quality dentistry as soon as dental problems arise. We promise to base your treatment on your dental health needs, not on your insurance policy. Although you may have dental insurance coverage, some procedures may not be covered. A deductible or a copayment may be required. Our front office staff will be happy to review your dental benefits coverage with you.

In an effort to assist you in financing your recommended dental treatment, our office offers the following **options** for those with **dental insurance:**

1. Payment for entire treatment may be paid in full at the start of treatment and then your insurance reimbursement will be sent directly to you. Your fee can be reduced by **5% if you pay in full with cash or check at the time of service.**
2. We will **estimate** your insurance coverage and you pay the total **estimated co-pay** at the beginning of your treatment or equal payments at each appointment if multiple visits are required to complete treatment.
3. Extended payment plans can be arranged through CareCredit. Financing will be for the entire cost of treatment offered at 0% interest free for 12 months. You would then be directly reimbursed by your insurance company.

Our office also offers the following payment arrangements for those with **no insurance coverage:**

1. Payment for entire treatment may be paid in full at the start of treatment. Your fee can be reduced by 5% for all treatment **other than cleanings** by **paying in full with cash or check** at the time of service.
2. If your treatment requires more than one appointment, we can further assist you by dividing your treatment cost by the number of appointments required to complete your treatment.
3. We can assist you in obtaining an interest-free extended payment plan for 12 months with CareCredit. You may also obtain financing through your bank or financial institution.

We appreciate the opportunity to serve and assist you in obtaining the highest quality dental care.

Sincerely,
Dr. Eder and Staff
Brownsburg Family Dental Care

I have read, understand and agree to this financial policy. I also understand that I am responsible for all charges that are incurred while undergoing treatment at Brownsburg Family Dental Care.

_______________________________________ Date_______________________________

Signature of Patient or Responsible Party