Patient Registration

Name (First) ____________________(Middle) __________________ (Last) ____________________

Social Security Number__________________________________ Date of Birth _____/_____/_____

Address ____

City ___________________________________ State _______________ Zip Code _______________

Home Phone Number ______________________ Cell Phone Number ________________________

Work Phone Number ______________________ Employer _________________________________

Emergency Contact ____________________________ Phone Number__________________________

Person Responsible For Payment _______________________ Phone Number __________________

Address ____

City ____ State ______________ Zip ______________

Patient Medical/Dental History

1. Are you currently under any medical treatment? ______________________________________

2. Have you had any major operations? Please List. ______________________________________

3. Have you been diagnosed with any of the following conditions? Please circle yes or no.

A Heart Ailment	Y	N
High/Low Blood Pressure	Y	N
Diabetes	Y	N
Tumors or Growths	Y	N
Hepatitis A	Y	N
Hepatitis B	Y	N
Hepatitis C	Y	N
HIV/AIDS	Y	N
Liver or Kidney Disease	Y	N
Stomach or Intestinal Disease	Y	N
Other (Please explain below)	Y	N

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Patient Medical/Dental History Continued

4. Please list all medications you are currently taking.

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5. Please list any allergies.

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___

6. Have you ever suffered from prolonged bleeding? ___

7. Do you clench or grind you teeth ? ___

8. Do your gums bleed? ___

9. Could you be pregnant? ___

10. When and where were your last dental x-rays taken? ___

11. How did you hear about us?

Friend ___ Internet ___ Phonebook ___ Other ___

Signature ___ Date ___

Signature ___ Date ___

Signature ___ Date ___

Privacy Policy

I acknowledge that upon my request there is a copy of the privacy policies available for my review. I also understand that if I have any questions or concerns about the policies I may address them to the receptionist.

Initial:______________

Finance Policies

1. All co-payments and/or deductibles are due the day of treatment.
2. Each patient is responsible for any charges unpaid by the insurance company.
3. A $10.00 monthly handling fee may be added to the account, not paid in full within 30 days.
4. Accounts showing no payment for 90 consecutive days will be considered delinquent and turned over to the Credit Bureau. A handling fee of 35% will be added to the bill at this point.

Initial:______________

Insurance Policyholder Information

The policyholder is the person whose name the policy is in. This may not be you.

Name of Policyholder________________________ Date of Birth of Policyholder_______________

Policyholder Social Security Number ____

Insurance ID number____

Insurance Company's Name____________________ Insurance Phone Number__________________

Insurance Address_______________________________ City____________ State_____ Zip________

List (if any) Secondary Insurance Information____

1. The patient is responsible for payment of services provided.
2. We have no way of knowing all the different insurance company plans.
3. We will file insurance claims as a courtesy but cannot take responsibility for how the insurance company will pay for claims made.
4. Some procedures have no insurance coverage. Most procedures have a co-payment and/or deductible, some procedures may cost more than the insurance company will cover.

Assignment of Benefits/Release of Information

By signing below I authorize payment of dental benefits to Dr. William J. Coco and also allow the release of the information necessary to process the dental claims. I understand that I am ultimately responsible for all charges incurred from treatments received and that the processing of my dental claims are a courtesy that is provided by Dr. William J. Coco's office.

By signing below you understand and are agreeing to all of the statements listed above

Signature____________________________________ Date______________________________