Patient registration form – please be sure to complete entire form and sigh to avoid delay in appointment time.

Provider information: AC Dental of Linden

Provider information

Patient Last Name: _____ First:_____ MI:_____

Street: _____City:_____ State:_____ Zip:_____

Home phone: _____Work phone:_____ Cell phone: _____

SSN#:_____ DOB: _____ Age: ____ Marital Status: S-M-D-W-SEP

Employer: _____ Address: _____ Status: F/T- P/T

How long employed: _____ Occupation: _____

Driver License #:_____ State: _____

Email Address: _____

Pharmacy/ #: _____

SPOUSE/PARENT INFORMATION

His/ Her Name: _____ Relationship: _____ DOB_____

SSN #:_____ Employer: _____ Work phone:_____

PERSON RESPONSIBLE FOR ACCOUNT

His/ Her name: _____ Relationship:_____ DOB:_____

Billing address (if different):_____

Zip: _____ Insured's DOB: _____ Insurer's SSN sec#: _____

Relationship to insured: Self: _____ Spouse: _____ Child: _____ Other: _____

Insurance Company: _____ Phone: _____

Ins Co Address: _____

Insured's ID/policy #: _____ Group#:_____

SECONDARY INSURANCE INFORMATION

Insured's Last Name: _____ First: _____ M.I: _____

Street (if different): _____ City: _____ State: _____

Zip: _____ Insured's BD: _____ Insured's SSN: _____

Relation to Insured: Self ( ) Spouse ( ) Child ( ) Other ( )

Insurance Comp: _____ Phone: _____

Ins. Comp Address: _____

Insured's ID/Policy #: _____ Group ID: _____

I grant permission for the above named medical provider to take photographs (if deemed necessary) related to my condition.

PATIENT SIGNATURE: _____ **DATE:** _____

INSURANCE / PAYMENT AGREEMENT

I hereby assign the policy benefits to the above named dentist (provider of services) and authorize payment for professional services rendered. I further authorize the attending dentist to release any information concerning my examination of treatment to my insurance company and use of this form or a copy for all insurance submissions on my behalf. I agree to be personally responsible for any unpaid balance or co-payment due as a result, and, furthermore, if I receive any payments from my insurance company in error or due to standard procedure, I will immediately sign them directly over to the provider. All recommended testing in my responsibility to have done in a timely manner.

I understand that in the event that this account needs to be places with an attorney or a collection agency because of an unpaid balance remaining on my account. I hereby agree and promise to pay interest of 1.5% per month of the outstanding balance to be calculated starting from my last date of serviced. In addition, I also agree and promise to pay a collection fee of $100.00 of 35% of the total balance due, whichever is greater, upon placement with an attorney or collection because of an unpaid balance remaining on my account. Court costs and attorney fees may also be assessed. I understand that I am responsible for my bill and that insurance claims for service do not relieve me of my responsibility to pay my account within the time allowed by this office's credit policy. In addition, I agree that this contract will remain in force for all services regardless of the date signed. There may be a $35.00 charge for any broken appointments without 24 hours' notice. There will be a $35.00 fee imposed for checks returned for any reason.

PATIENT / AUTHORIZED GUARDIAN: _____ **DATE:** _____

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.

SIGNATURE HERE: _____ **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: Refusal ( ) Communication Barrier ( ) Emergency ( ) Other ( )