FRIENDLY DENTAL CARE

Dr. Bruce Baker • Dr. Paul Brown • Dr. Robert McDavid • Dr. Jessica McDavid

611 North Broad Street • Lancaster, Ohio 43130 • (740) 687-6105

PATIENT REGISTRATION FORM

Patient Name _____

Responsible Party _____
First Name Initial Last Name

Address _____

City _____ State _____ Zip Code _____

Phone: (Home) _____ (Work) _____ (Cell) _____

Email: _____ Select best option for appointment confirmation.

___ Home ___ Work ___ Cell ___ Text ___ Email

Employer _____

Address _____

Name & Address of Nearest Relative (not living with you) _____

_____

Referral Source _____

DENTAL INSURANCE INFORMATION

Subscriber Name _____ S.S.# _____ D.O.B. _____

Carrier Name & Address _____

_____

Group Name _____ Group # _____

Does this plan cover all family members? _____ Yes _____ No

If no specify those ***NOT*** Covered.

ASSIGNMENT OF BENEFITS

I authorize payment of dental benefits to myself or the named provider for professional services rendered.

Signed _____ Date _____
(Subscriber)

RELEASE OF INFORMATION

I authorize the release of any dental information necessary to process this claim.

Signed _____ Date _____
(Patient or parent if Minor)

Additional Dental Coverage? _____ Yes _____ No

DR. BRUCE BAKER • DR. ROBERT MCDAVID • DR. JESSICA MCDAVID

Friendly
DENTAL CARE

611 NORTH BROAD STREET • LANCASTER, OHIO 43130 TELEPHONE (740) 687-6105

DENTAL INSURANCE

We are pleased that many of you have a Dental Insurance Policy that will help supplement the cost of your needed dental treatment. We will do everything we can to help maximize your benefits.

If you provide us with your insurance form or information, we will be happy to complete and forward your claim at no charge. In many cases we can do this for you electronically the very same day of your appointment.

We certainly hope that your insurance covers all or most of your dental expenses. However, only the most expensive policies provide 100% coverage. Some pay only 50% of our fees.

Our insurance specialists have spent many hours studying to become knowledgeable and familiar with the different insurance companies, but unfortunately, the companies continue to change their policies regarding benefits, we cannot give an exact estimate of your expected benefits, only an educated guess.

Insurance companies commonly take as long as 60 to 90 days to process claims and pay. Because a major part of your dental expense is deferred, we require payment of your estimate portion in advance or at the time of service to defray current expenses. In this way we can keep our fees down and provide savings to you!

If an overpayment is received from your insurance carrier we will send you the balance of the overpayment. If the insurance dose not pay as much as you or we expected you will be responsible for the remaining balance. Payment in full is expected at that time.

By signing below, I verify that I have read and agree to the information contained in this insurance registration form.

Patient Signature	Date	Witness

DR. BRUCE BAKER • DR. ROBERT MCDAVID • DR. JESSICA MCDAVID

Friendly
DENTAL CARE

611 NORTH BROAD STREET • LANCASTER, OHIO 43130 TELEPHONE (740) 687-6105

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to may requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____ Relationship to Patient: _____

Signature: _____ Date: _____

OFFICE USE ONLY - I attempted to obtain the patient's signature in acknowledgment on the Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

Date:	Initials:	Reason: