mahairi
DENTAL CENTER

Patient Registration Form

ACKNOWLEDGEMENT OF RECEIPT OF HIPPA NOTICE OF PRIVACY PRACTICE

Date:_____

Patient Name:_____ DOB:_____

First Last M.I

Address:_____ Address 2_____

City:_____State/Zip_____

Home Phone:_____ Cell Phone:_____

Work Phone:_____ Ext:_____ Email :_____

SS#_____ DL#_____ Gender Male/ Female

What is the best way to contact you? Home/ Cell/ Email/ Work/ Mail (circle one)

Marital Status: Single/ Married/ Divorced / Widowed / Partnered Spouse's Name:_____

Employer/ School Name:_____ Occupation:_____

Address:_____ City/ State/ Zip:_____

Who may we thank for referring you?_____

Primary Dental Insurance Information

Subscriber's Name:_____ Relationship:_____

Birthdate:_____ SS#_____ ID#_____

Insurance Company:_____ Group#:_____

Insurance Phone:_____ Insurance Address:_____

Employer's Name:_____ Work Phone:_____

Secondary Dental Insurance Information

Do you have secondary dental insurance? YES/ NO

Subscriber's Name:_____ Relationship:_____

Birthdate:_____ SS#_____ ID#_____

Insurance Company:_____ Group#:_____

Insurance Phone:_____ Insurance Address:_____

Employer's Name:_____ Work Phone:_____

ACKNOWLEDGEMENT

I acknowledge that I have received a copy or have viewed the displayed copy of Mahairi Dental Center HIPPA Notice of Privacy Practices

_____ _____

Patient Name **Patient Signature**

_____

Date

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Financial Agreement and Office Policy

For the convenience of our patients, the following office policy, financial agreement, and the consent has been established for your review.

We accept Cash, Credit, and Debit.

Dental Insurance

As a service to our patients, we will file your dental insurance claims. We work with your insurance company to provide the most accurate estimate of your copays. It is the patient's responsibility to provide the correct insurance information at the first visit. Insured patients are responsible for, and should be prepared to pay all amounts not covered by the dental plan provided. Please be aware that with insurance plans, paying only a portion of treatment cost, we can only estimate what your insurance company will pay. The maximum amount for insurance companies to pay is 60 days, after this time frame, patients are responsible of paying balance.

Payment Plans

We do offer payment plans for our patients with no dental coverage, all depending on procedures done the day of appointment. Please speak to us for further information. **Some Restrictions Apply.**

Release of Information and Assignment of Benefits

The undersigned has read the above and agrees whether he/she signs as a responsible party or as a patient, to pay Mahairi Dental Center, in full without regard to insurance coverage. The undersign agrees to pay any collection fees. The undersign further agrees any/ all insurance benefits to be paid directly to Mahairi Dental, agrees to release any information requested by the insurance carrier, and allows Mahairi Dental to use patient photos (withholding all names) as educational tools within the practice.

_____ _____

Printed Name Date

X_____ _____

Signature (Patient or responsible party) Relationship