Mukilteo DENTAL Center

PATIENT REGISTRATION

PATIENT INFORMATION

First Name MI Last

Preferred Name: _____ Date of Birth: _____

Marital Status: ☐ Single ☐ Married ☐ Other: _____

Address: _____

City: _____ Zip Code: _____

Cell: _____ Work: _____ Ext: _____

Home: _____ Email: _____

You prefer to be contacted by: ☐Cell ☐Work ☐Home ☐Email

OK to leave detailed Messages? ☐ Yes / ☐ No / ☐ Cell Only

Offer you an earlier appointment if available? ☐ Yes / ☐ No

Patient Employer / School: _____

Spouse Name / Employer: _____ / _____

How did you hear about our office: _____

We would love to know more about you. Anything you would like to share?

PRIMARY DENTAL INSURANCE

Subscriber Name (First) (MI) (Last)

ID/SSN: _____ Date of Birth: _____

Relationship to Patient: _____

Ins. Co: _____

Group Number: _____

Employer: _____

SECONDARY DENTAL INSURANCE

Subscriber Name (First) (MI) (Last)

ID/SSN: _____ Date of Birth: _____

Relationship to Patient: _____

Ins. Co: _____

Group Number: _____

Employer: _____

Emergency Contact (someone not living in your household):

Name: _____ Relationship: _____ Phone: _____

ASSIGNMENT AND RELEASE

I hereby authorize my insurance benefits to be paid directly to the dentist of Mukilteo Dental Center.

I understand that I am responsible for all costs of dental treatment regardless of insurance coverage.

I hereby authorize the dentist to administer such medications and perform such diagnostic, photographic, and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I also authorize the dentist to release any records & x-rays as requested by third party payors and/or other health professionals. Insurance: We do accept assignment of insurance benefits as a courtesy to you. However, we require payment of your out-of-pocket charges at the time of service.

Appointment Changes: Appointment times are reserved exclusively for you. Please notify us within 48 business hours if you need to cancel or reschedule your appointment to avoid an administrative fee of $75. If there is a valid emergency, we will make every effort to accommodate you. Finance Charges: Any unpaid balance after 30 days will be charged an annual interest rate of 12% as outlined in the attached financial policy.

I have read the policy above and I understand and agree to it.

Signature of Patient or Responsible Party _____ Date: _____