PINNACLE
DENTAL ASSOCIATES

Patient Registration

Date_____

From whom or how did you hear about our office? _____

Patient Information

Patient Name_____ DOB___/____/_____ _____ ☐M ☐F
First M.I. Last Age

Address_____ City, State, Zip_____

Email_____ Employer_____

Home Phone #(___)_____ Work #(___)_____ ext.____ Cell #(____)_____

Social Security Number _____-_____-_____ Driver's license #_____ State_____

I would like to receive correspondence via **email**: ☐ Yes ☐ No **text message**: ☐ Yes ☐ No **Both**: ☐ Yes ☐ No

Person to contact if unable to reach you directly

Name of Friend or Relative _____ _____
(not living with you) First M.I. Last Relationship

Home Phone #(___)_____ Work #(___)_____ ext.____ Cell #(____)_____

Person Responsible for Account

Please complete this section if other than the above person.

Patient Name_____ DOB___/____/_____ _____ ☐M ☐F
First M.I. Last Age

Please check one: ☐Father ☐Mother ☐Spouse ☐Partner ☐Guardian Legal Documentation Needed: ☐Yes ☐No

Address_____ City, State, Zip_____

Employer_____ Social Security Number _____-_____-_____

Home Phone # (___)_____ Work # (___)_____ ext.____ Cell #(____)

Primary Insurance

Policy Holder's Name _____ _____ DOB___/____/_____
Relationship to patient

Insurance Company _____ ID # _____ Group #_____

Insurance Company Phone #_____ Secondary insurance: ☐Yes ☐No

Method Of Payment

☐ I do not have dental insurance and I agree to pay for any and all treatment IN FULL on the day of service.

☐ I have dental insurance and am responsible for paying my estimated portion on the day of services are rendered.

Authorization: All Patients or Guardians Must Initial And Sign

I authorize the dentist to perform diagnostic procedures and treatment, including administration of medicine, local and general anesthetics, and extractions along with other surgical and dental procedures that may be necessary for proper dental care. _____initial

I authorize the use of a third party company to verify my employer's insurance company and insurance plan. _____initial

I agree that I am responsible for paying my balance on the day services are rendered. _____initial

I am responsible for all legal and business costs related to non-payment of accounts including collection costs. _____initial

I understand that any balances unpaid after 60 days will revert to my responsibility, regardless of intended payee (insurance, financier, etc.) _____initial

X_____ _____
Patient or Guardian's Signature Date