PATIENT REGISTRATION FORM

(PLEASE PRINT)

MAIN FAMILY DENTAL CARE, PC
1905 Main Street
Davenport, IA 52803

(563) 323-2571 • (563) 323-1069 Fax
www.mainfamilydentalcare.com

Date _____ Reason you are here today _____

PATIENT INFORMATION

☐ Mr. ☐ Mrs.
☐ Ms. ☐ Miss
☐ Dr.

_____
First Name M.I. Last Name

Preferred Name _____ SS # _____

Address _____ Home (_____) _____

City _____ Cell (_____) _____

State _____ Zip _____ Work (_____) _____

Email _____ ☐ I would like to receive correspondence by email.

Sex ☐ M ☐ F Age_____ Birthdate_____

Name of Employer _____ Phone (_____) _____

Address _____

City _____ State _____ Zip _____

In case of an emergency, who should we call? _____ **Phone (_____)** _____

Their relationship to you _____

How did you hear about us? ☐ Friend (their name) _____ ☐ Employer _____

☐ Insurance Co. _____ ☐ Internet (which site) _____

NOTICE OF FINANCIAL RESPONSIBILITY

I acknowledge that the cost for dental treatment is my responsibility. Any charges for services not covered by my insurance policy are my responsibility and I am liable for any charges resulting from treatment that I authorize by oral or written agreement or upon receipt of treatment.

All past due accounts are subject to a finance charge of 1.5% per month or maximum rate allowed by law. The undersigned responsible party, agrees to be personally responsible for all charges. If at any time, or for any reason the undersigned is unable to pay for services when due, the undersigned agrees to pay and authorizes Main Family Dental Care, PC. to bill their account finances charges as described above. In the event it becomes necessary for Main Family Dental Care, PC. to incur collection costs or institute suit to collect any amount due under this agreement, the undersigned also agrees to pay collection fees and expenses, including reasonable attorneys' fees and court cost plus all legal fees if incurred for collection and submits to jurisdiction and venue in Scott County, IA.

Patient Name: (Print) _____

Patient/Personal Representative Signature: _____

Patient unable or refused to sign acknowledgement: _____ Witness: _____

PRIVACY NOTICE

A copy of our privacy practices has been provided. Your signature indicates that you have received access to our policies and that you agree with them.

I received a Notice of Privacy Practice on _____. Signed _____
Date

CONSENT FOR TREATMENT OF MINOR CHILD

Name of Person Responsible for Minor Child _____

Address _____ Phone (_____) _____

City _____ State _____ Zip _____

Permission is hereby granted to Main Family Dental Care, PC and staff, after parent/guardian consultation, to do all such things as may be necessary to diagnose, treat and care for the needs of _____ who is a minor and under the care of his/her parents or legal guardian.

Signature of Parent or Guardian _____ Date _____

PRIMARY INSURANCE

Person Responsible for Account _____ _____
Last Name First Name Middle Initial

Relationship to Patient _____ Birthdate _____ SS # _____

Address (if different from patient): _____ Phone (_____) _____

City _____ State _____ Zip _____

Person Responsible Employed by_____ Occupation _____

Address _____ Phone (_____) _____

Insurance Company _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? ☐ Y ☐ N

Subscriber Name _____ Birthdate _____ Relation to Patient _____

Address (if different from patient): _____ Phone (_____) _____

City _____ State _____ Zip _____

Subscriber Employed by_____ Phone (_____) _____

Insurance Company _____ SS# _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to
Name of Insurance Company(ies)

Main Family Dental Care, PC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above-named insurance Company(ies)and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient