Patient Registration

Please Complete the Following Confidential Information

Name:_____ Preferred Name:_____
First Middle Last

Date of Birth:_____ Social Security #:_____ Marital Status: S M W D

Home Address:_____
Street City State Zip Code

Phone: Home:_____ Work:_____ Cell:_____

Employer:_____ Occupation:_____

Emergency Contact:_____ Relationship to Patient:_____

Phone #: (H) _____ (W) _____ (C) _____

Person Financially Responsible for this account:_____

Who may we thank for referring you to our office?_____

Dental Insurance Information

Insurance Company:_____ Group Number:_____

Claim Address:_____ Phone Number:_____

Policy Holder's Name:_____ Policy Holder's Employer:_____

Relationship to Patient:_____ SSN:_____ Policy Holder's Date of Birth:_____

Office Policy

- Payment is due in full at time of treatment. If you have insurance, we will gladly file your claim and the insurance company will pay you directly.
- You are responsible for your account regardless of estimated insurance coverage.
- There is a $25.00 fee for all returned checks.
- Davidian & Associates requires a cancellation notice of more than 2 business days for all sedation appointments. If this requirement is not met, a $265.00 cancellation fee will be charged. If a sedation appointment is cancelled the morning of your appointment or after hours the day before, a $500.00 cancellation fee will be charged. In case of sickness, the cancellation fee will be waived upon receipt of a doctor's note confirming the contraindication of the sedation to the illness. Extreme or unusual circumstances will be reviewed on a case by case basis. For regular scheduled appointments, we require 2 business days notice. We reserve time specifically for you and not showing up or cancelling an appointment prevents others from being served.

The information I have provided is complete and accurate to the best of my knowledge. I consent to the procedures deemed necessary to diagnose my dental health . I agree to be responsible for payment of all services rendered. I authorize a credit check should I ask for credit.

Signature:_____ Date:_____

Email Address: _____