Patient Registration Form

Patient Information

First Name: _____ Last Name: _____

Address: _____

City, State, ZIP Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone:_____

E-Mail Address: _____

Birth Date: _____ Social Security #: _____

□ Male □ Female

Marital Status: □ Single □ Married/ Domestic Partnership □ Divorced □ Widowed

Referred to us by: □ another patient _____ □ Insurance □ Other_____

Insurance Information □ No Insurance

Insured: □ Self □ Spouse/ Partner □ Parent

Name of Insured: _____

Birth Date: _____ Social Security #: _____

Employer: _____ Insurance Carrier: _____

Group #: _____ Carrier ID #: _____

Patient Responsibility

Bloomfield Avenue Dental Associates recommend that all patients verify eligibility and benefits with their insurance company prior to receiving dental services. While we make every effort to acquire all information about your dental insurance coverage based on the information you provide us, we are not responsible for informing patients of insurance coverage. Please be aware that not all dental services are covered by all insurance carriers. Non-covered procedures must be paid in full at the time services are received.

If your insurance company denies payment, the guarantor of the account (you) will become responsible for payment. Once the balance is deemed a patient's responsibility, Bloomfield Dental Associates will bill you directly and the balance is requested in full upon receipt of the statement.

Time has been specifically reserved for your dental appointment, procedure or treatment. Please call at least **48 hours** ahead of time if you must cancel an appointment. There is a **$50 charge** if you fail to show up for a scheduled appointment or cancel with less than **48 hours notice**.

I have received a copy of the notice of privacy practice as required by the Health Insurance Portability and Accountability Act of 1996 (HIPPA). To the best of my knowledge, the questions on this form and the medical history have been accurately answered.

Patient Signature:_____ Date:_____