TODAY'S DATE________________________________

PATIENT REGISTRATION
DAVID A. GROAT, D.D.S.

PATIENT INFORMATION

FIRST NAME	MIDDLE INITIAL	LAST NAME	NICKNAME OR PREFERRED NAME
EMAIL			
ADDRESS			BIRTHDATE
CITY	STATE	ZIP	☐ MALE ☐ MARRIED ☐ FEMALE ☐ SINGLE
HOME PHONE ☐ PREFERRED	CELL PHONE ☐ PREFERRED	WORK PHONE ☐ PREFERRED	SOCIAL SECURITY NUMBER

IF PATIENT IS A MINOR, PROVIDE THE FOLLOWING	PARENT/LEGAL GUARDIAN FIRST NAME LAST NAME		RELATIONSHIP TO PATIENT ☐ PARENT ☐ GRANDPARENT ☐ OTHER ☐ LEGAL GUARDIAN		
	EMAIL ADDRESS				
	ADDRESS ☐ SAME AS ABOVE		CITY	STATE	ZIP
HOME PHONE ☐ PREFERRED	CELL PHONE ☐ PREFERRED		WORK PHONE ☐ PREFERRED	SOCIAL SECURITY NUMBER	
WITH WHOM DOES THE CHILD RESIDE? ☐ MOTHER ☐ FATHER ☐ BOTH ☐ OTHER (PLEASE SPECIFY)________________					

SPOUSE NAME

SPOUSE NAME	PHONE NUMBER ☐ PREFERRED	CELL NUMBER ☐ PREFERRED	
ADDRESS ☐ SAME AS ABOVE	CITY	STATE	ZIP

THE BIGGEST COMPLIMENT OUR PATIENTS CAN GIVE US IS THE REFERRAL OF FAMILY & FRIENDS

WHOM MAY WE THANK FOR REFERRING YOU? PLEASE PROVIDE FULL NAME	ARE THEY A PATIENT HERE?	☐ YES ☐ NO – CHOOSE BELOW
HOW DID YOU HEAR ABOUT OUR OFFICE? ☐ OUR WEBSITE ☐ BUILDING SIGN ☐ YOUR EMPLOYER ☐ MAILER/UNION HALL ☐ PUBLIC EVENT ☐ INSURANCE COMPANY ☐ ONLINE SEARCH ☐ SOCIAL MEDIA ☐ DENTAL CENTER EMPLOYEE________________		

IF YOU HAVE DENTAL INSURANCE, PLEASE PROVIDE THE FOLLOWING & YOUR INSURANCE CARD

PRIMARY CARRIER

INSURANCE COMPANY NAME	INSURANCE PHONE
EMPLOYER NAME	EMPLOYER PHONE
PRIMARY INSURED NAME	
BIRTH DATE	RELATIONSHIP TO PATIENT
INSURED INSURANCE I.D. NUMBER	GROUP NUMBER
INSURED SOCIAL SECURITY	
IF STUDENT, COLLEGE NAME	☐ FULL TIME ☐ PART TIME

SECONDARY CARRIER

INSURANCE COMPANY NAME	INSURANCE PHONE
EMPLOYER NAME	EMPLOYER PHONE
PRIMARY INSURED NAME	
BIRTH DATE	RELATIONSHIP TO PATIENT
INSURED INSURANCE I.D. NUMBER	GROUP NUMBER
INSURED SOCIAL SECURITY	
IF STUDENT, COLLEGE NAME	☐ FULL TIME ☐ PART TIME

FINANCIAL INFORMATION CIRCLE ONE: PRIVATE PAY PRIVATE INSURANCE EMPLOYER INSURANCE

PATIENT REGISTRATION

ACKNOWLEDGEMENT & CONSENT

Acknowledgement of Insurance Payment Authorization: I hereby authorize and direct payment of the dental insurance benefits otherwise payable to me for services rendered, directly to David A. Groat, D.D.S. In the event that the insurance company misdirects payment to me, I understand that I am responsible to immediately remit such payments to David A. Groat, D.D.S.

Acknowledgement of Financial Responsibility: I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that either a 1-½% late charge (18% APR) or a $15 late charge per late payment may be added to my account. I further agree to inform David A. Groat, D.D.S. of any address or phone number change within 30 days of such a change. In the event I fail to do so I authorize David A. Groat, D.D.S. to use all due means, including the use of credit history records, to ascertain my new address for billing purposes.

Cancellation Policy: I agree if I am unable to keep an appointment I will give 24 hours notice. If I fail to give 24 hour notice for cancellation or if I fail to show for an appointment it will result in the following fees:

Hygiene Appointment......$50.00 **Dental Appointment........$100.00**

__________ **Initial** ____________**Initial**

Notice of Privacy Practices: I acknowledge that I have received the practice's Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy Practices.

Acknowledgment of Dental Materials Fact Sheet: I acknowledge that I have received and read the "The Facts About Fillings" prior to starting restorative dental work at David A. Groat, D.D.S.

PATIENT PRINT NAME DATE

PATIENT/PARENT/RESPONSIBLE PARTY SIGNATURE DATE

RELATIONSHIP TO PATIENT