Print Form

FRESH DENTAL CARE REGISTRATION FORM

PATIENT INFORMATION

Patient's last name: First: Middle:			Sex: ◯ Male ◯ Female	Marital status: ◯ Single ◯ Married ◯ Widowed
Social Security No.:	Birth date:	Preferred Communication (statement/reminder) ◯ Mail ◯ Email ◯ HomePhone ◯ CellPhone ◯ WorkPhone ◯ TxtMsg		
Home address - Street:		City:	State: IL	ZIP Code:
Home phone:	Cell Phone:	Email:		Text Msg:
Employer:	Work Address:			Work phone:
Whom may we thank for referral?	Friend/Family member Name:			Insurance:
Search Engine:	Directory Services:	Coupon:		Other:

INSURANCE INFORMATION

Primary Insurance Company:				Phone:
Insurance Company Address:				
Patient's relationship to subscriber:	◯ Self ◯ Spouse ◯ Child ◯ Other			
Subscriber Name:	Subscriber's SSN/ID:	Birth date:	Group no.:	Policy no.:
Secondary Insurance (if applicable)				Phone:
Insurance Company Address:				
Patient's relationship to subscriber:	◯ Self ◯ Spouse ◯ Child ◯ Other			
Subscriber Name:	Subscriber's SSN/ID:	Birth date:	Group no.:	Policy no.:

CONSENT FOR TREATMENT

The patient or his representative recognizing the need for care consents to all services as ordered by our office, including examination, treatment, laboratory, and x-ray procedures, minor or emergency surgical treatment, or other treatment rendered under specific instructions of the dentist. I understand that a minimum 48 hours notice is required for cancellation of appointments. A broken appointment fee may be charged to my account, and is payable by me if 48 hours notice is not given.
I confirm that I have received a copy of Fresh Dental Care's Notice of Privacy Practices, in electronic or paper format.

Patient/Parent/Guardian Signature	Date	Relationship
_____	_____	_____

INSURANCE ASSIGNMENT AND RELEASE

Our office, as a courtesy, will accept assignment of your dental insurance whenever possible. However it does not absolve the patient of full responsibility for the charges incurred for treatment rendered. The estimate of what an insurance company will pay is considered a guideline until the final insurance payment is received and the patient's account is reconciled. Our office will make every effort to assist our patients in obtaining insurance information from our patients' insurance company. An insurance policy is a contract between the patient and their insurance company; therefore our office cannot guarantee what an insurance company will eventually pay.

Not all of the dentists participate in all insurance plans. To insure you are covered properly, you must supply all necessary insurance information to our office prior to your treatment. If you insurance company requests any additional information from you for treatment you have received, you will need to contact our office to check if we have received the same request and if we can provide the additional information to facilitate the insurance claims.

Our office will submit insurance claims on behalf of our patients as a courtesy. Any balance not paid by the insurance company after 60 days shall be the sole responsibility of the patient.

I hereby authorize Fresh Dental Care to release all necessary information to insurance companies concerning the treatment and I hereby assign directly to Fresh Dental Care, Ltd all payments for services rendered to my dependants or myself. I authorize the use of this signature on all insurance submissions. I understand and accept that it is my responsibility to pay for all of my dental treatment rendered by Fresh Dental Care, Ltd.

Patient/Parent/Guardian Signature	Date	Relationship
_____	_____	_____