Center for Advanced Dentistry
BRAD SAMMONS, DDS
For Health. For Beauty. For Life.

PATIENT REGISTRATION

Todays Date:_____

Patient's Name:_____ Sex: M / F Birthdate:_____

Home Address_____ City:_____ State:_____ Zip:_____

Home Phone #: _____ Cell Phone # _____ Social Security #_____

Email:_____ Marital Status: Single, Married, Child, Other

Employer:_____ Work # _____ Full time student? Yes No

EMERGENCY CONTACT: Name _____ Number _____

Name of spouse (Parent if minor) _____ Spouse's employer: _____

Spouse's Soc. Sec. #_____ Spouse's Birthdate:_____ Work phone #_____

How did you hear about our office?_____ Reason for visit:_____

Is there anything we can to do to make this appointment a better experience for you? _____

_____

(Primary Carrier) Subscriber name:_____ DOB:_____ SS / ID #: _____

Employer name:_____ Insurance Co:_____ Phone #: _____

Insurance Co Address:_____ Group #_____ Relationship:_____

(Secondary Carrier) Subscriber name:_____ DOB:_____ SS / ID#: _____

Employer name:_____ Insurance Co:_____ Phone #: _____

Insurance Co Address:_____ Group #_____ Relationship:_____

Medical plan Subscriber name:_____ DOB:_____ SS / ID#: _____

Employer name:_____ Insurance Co:_____ Phone #: _____

Insurance Co Address:_____ Group #_____ Relationship:_____

FINANCIAL POLICY

Thank you for choosing our office as your dental health care provider. We are committed to providing you with the highest quality lifetime dental care, so that you may fully attain optimum oral health. Payment is due at the time service is provided. Our office accepts Cash, Check, MasterCard, Visa, and Care Credit.

Please Note: Returned checks will be subject to additional fees. In the case it becomes necessary for our office to enlist a collection service and/or legal assistance, you will be responsible for any collection and/or legal charges incurred

Cancellation Policy: To provide our patients with the best care, we require a 24hr notice to cancel / reschedule your appointment. A fee of $25 will charged for all failed or short notice canceled appointments.

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY BENEFITS DIRECTLY TO MY DENTAL OFFICE.

Signature: _____ Date:_____