PATIENT REGISTRATION

Date

10522 South Cicero Ave. Suite 404 Oak Lawn, IL 60453 • 708-422-7733 • www.RogersDental.com

CONTACT INFORMATION

Patient Name	Date of Birth

Street Address

City	State	Zip Code

Home Phone with Area Code	Cell Phone with Area Code	e-mail
( )	( )	

GETTING TO KNOW YOU

Who may we thank for referring you to our office?

Emergency Contact Name	Home Phone with Area Code	Cell Phone with Area Code
	( )	( )

PATIENT ACCOUNT INFORMATION

Occupation	Employer

Street Address

City	State	Zip Code

Work Phone with Area Code
( )

SPOUSE (IF MARRIED)

Spouse Name	Employer

PERSON WHO IS RESPONSIBLE FOR THIS ACCOUNT

Name	Home Phone with Area Code	Work Phone with Area Code
	( )	( )

Street Address

City	State	Zip Code

Relationship to Patient	Social Security Number

Please complete insurance info and sign agreement on next page. Thank You.

DENTAL INSURANCE (IF COVERED BY A PLAN)

Insured Name	Employer

Insurance Company Name

Group Number	Insurance ID Number

Relationship to Patient	Insured Date Of Birth

SECONDARY INSURANCE (IF ANY)

Insured Name	Employer

Insurance Company Name

Group Number	Insurance ID Number

Relationship to Patient	Insured Date Of Birth

OFFICE INFORMATION, FINANCIAL, AND TREATMENT CONSENT AGREEMENTS:

I hereby agree to all the following declarations numbered 1 through 6 on this page. Please read, sign, and date.

1.) I authorize the doctor or his designated staff to take necessary x-rays, study models, photographs, or any other diagnostic tools deemed necessary by the doctor to complete a thorough diagnosis for (name of patient)______________________________ dental needs and determination of treatment.

2.) When the doctor has completed diagnosis, I then will authorize the doctor to perform recommended treatment mutually agreed upon by me, and with the doctor's assistance as needed to provide the proper care.

3.) I accept the use of anesthetics, sedatives and/or other medications as needed to treat my dental conditions. I fully understand that using medications as well as anesthetics do carry certain risks. I also understand that I may ask for a complete explanation of any and all of these risks from the doctor.

4.) 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 services are rendered, unless some other form of payment plan has been agreed upon between this dental office and the responsible party. In the event payments are not received by the agreed upon time or dates, I understand that a monthly statement billing fee (based on my current account balance) can and will be applied to my account which I will be responsible for. If required I also understand a check of my credit history may be made. It is the responsible party's responsibility to request a payment plan if needed.

5.) I understand that appointment time is a valued commodity. I also understand that any missed appointments, or appointments changed less than 48 hours in advance will be subject to charge for that appointment. It is also my understanding that if it should become necessary to send my account to collection, I will be responsible for any and all costs incurred to collect the unpaid amount including any and all attorney's costs and court costs.

6.) If the patient is covered by dental insurance, I understand that the insurance contract is solely between the employer, insured employee, and the insurance company. This dental office has no control over what will be provided by the insurance company. As a courtesy to you, we do process insurance information and claims on your behalf. If no payment or action has been taken by the insurance carrier within 30 days after the claim was submitted, I acknowledge that the full amount of my balance is my responsibility.

Patient Signature (or Legal Guardian):______________________________ Date:______________

Responsible Party Signature: ______________________________ Date:______________