

Allen Creek Family Dentistry

6618-C 64th NE, Suite C Marysville, WA 98270

Phone: 360 651 2900 Fax: 360 651 7711

Patient Registration

Patient Information: Please Print

Full Name: _____ Preferred Name: _____

Date of Birth: ___/___/___ Age: _____ Social Security Number: ___-___-___

Home Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Cellular Phone: (____) _____

Mailing Address (If Different)

Mailing Address _____ City: _____ State: _____ Zip: _____

Employer / Member Information

Employer Name: _____ Occupation: _____

Work Phone: (____) _____ Extension: (____)

Dental Plan Name: _____ Group/Policy # _____

Dental Plan Phone Number: (____) _____ Address: _____

Spouse, Parent or Registered Guardian

Full Name: _____ Preferred Name: _____

Date of Birth: ___/___/___ Age: _____ Social Security Number: ___-___-___

Home Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Cellular Phone: (____) _____

Mailing Address (If Different)

Mailing Address _____ City: _____ State: _____ Zip: _____

Employer / Member Information

Employer Name: _____ Occupation: _____

Work Phone: (____) _____ Extension: (____)

Dental Plan Name: _____ Group/Policy # _____

Dental Plan Phone Number: (____) _____ Address: _____

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Patient Registration

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How did you hear about our dental practice ? _____

Emergency Contact

Please give us the name of a relative or friend **NOT** living in your household, who we could contact in case of an emergency.

Name: _____ Phone: (____) _____ Relationship: _____

Conditions Of Service

(please read and sign below)

Acknowledgement Of Privacy Rights:

I confirm that I have been informed of my rights to privacy regarding my protected health information, and I have been given the opportunity to review this office's *Notice of Privacy Practices* as required by the Health Insurance & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- ✓ Provide and coordinate treatment among health care providers who may be involved in my care
- ✓ Obtain payment from third-party payers for my health care services
- ✓ Conduct normal health care operations

Please name any other dependents or family members covered by this acknowledgement:

Appointments:

When an appointment is scheduled, this time slot is reserved especially for you. All missed or broken appointments without a minimum of 24 hours advanced notice are subject to a \$50.00 per half hour fee. To change or cancel appointments please call during our office hours, please note that our answering service will not accept appointment changes.

Payment is due at time of service.

Please be aware that accounts 60 days past due are subject to a minimum \$5.00 monthly processing fee at time of billing.

For Patients with Dental Insurance Only:

For those patients with dental insurance, Allen Creek Family Dentistry may release information about my treatment for purposes of processing any dental claims. I would like my benefits paid directly to Allen Creek Family Dentistry. I understand that processing of insurance claims is a courtesy and does not relieve me of my financial obligations resulting from any treatment provided by Allen Creek Family Dentistry. I agree to pay any outstanding balance remaining on my account after a period of 60 days regardless of slow insurance company processing, disputed claims, employer eligibility requests, information requests, lack of eligibility or benefits, or any other delays, etc. Allen Creek Family Dentistry will accept "insurance assignment" in lieu of my personal payment for a period of 60 days. After 60 days, unpaid insurance claims are due and payable by me. If I wish to file my own insurance claims, payment in full is due at time of service.

By signing below I have read and agree to the conditions of service with Allen Creek Family Dentistry.

Printed Name: _____ Signature: _____ Date: ____ / ____ / ____

For Office Use Only We were unable to obtain the patient's signature due to the following reason:

Patient refused to sign ___ Communication barrier ___ Emergency situation ___ Other _____