DALE FAMILY DENTISTRY
Caring for You...and Your Smile!

Registration

Kenneth G. Dale, DDS
2241 State Street, Suite C
New Albany, IN 47150
812-945-5100 (Tel) • 812-945-5101 (Fax)
www.DaleFamilyDentistry.com
info@DaleFamilyDentistry.com

Patient Information

Name _____ ____ _____
First MI Last

How do you wish to be addressed? _____

Today's Date: _____ Birthdate: _____ Age: _____

Social Security #: _____ Sex: ☐M ☐F

Residence: Street _____

City _____ State _____ Zip _____

Employer: _____ Occupation: _____

Check appropriate box:

☐Minor ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated

If Student, School's Name _____

School's City: _____ Full time? ☐Yes ☐No

Whom may we thank for referring you? / How did you learn of our office?

_____

Have you seen Dr. Dale before? ☐Yes ☐No

Previous Dentist: _____

Responsible Party

Responsible Party for Payment of this Account: ☐Same as Patient

Name _____ ____ _____
First MI Last

Relationship to Patient: _____

Birthdate: _____ Social Security #: _____

Residence: Street _____

City _____ State _____ Zip _____

Employer: _____ Occupation: _____

Is the Responsible Party a Patient in our Office? ☐Yes ☐No
☐No, but will be

Telephone & Contact

Home Phone : _____ Cell Phone: _____

Work Phone : _____ Dept./Ext.: _____

E-mail address: _____

Responsible Party Telephone Numbers (if different):

Home Phone : _____ Work Phone : _____

Where do you prefer to receive phone calls?

☐Home ☐Work ☐Cell Phone ☐Please do not call at Work

In the event of an Emergency, who should we contact?

Name : _____ Relationship : _____

Home Phone : _____ Work Phone : _____

Dental Insurance

Do you have dental insurance? ☐Yes ☐No

If Yes, please continue...

Name of Insured (Policy Holder): _____

Relationship to Patient: _____

Insured's Birthdate: _____

Insured's Social Security #: _____

Employer: _____

Employer's Address: _____

Insurance Company: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group #: _____ Employee ID #: _____

Do you have any additional Insurance? ☐Yes ☐No If Yes, continue...

2nd Policy Holder Name: _____

2nd Policy Holder Birthdate: _____ Social Security #: _____

2nd Policy Holder Employer: _____

2nd Insurance Co. Name: _____

Authorization & Payment

◆ I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. ◆ I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or other health practitioners. ◆ I authorize and request my insurance company to pay directly to the dentist Insurance benefits otherwise payable to me. ◆ I understand that my dental insurance carrier may pay less than the actual bill for services. ◆ I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents. ◆ I agree to pay collection costs and reasonable attorney fees in attempting to collect on this account or any future outstanding account balances. ◆ Interest charges (1½%/mo.,18% APR) may be applied to my past due account and there is a $15 fee for a returned check which I agree to pay. ◆ We do expect payment in full (less any estimated insurance) at each appointment, unless alternative financial arrangements are made. ◆ For your convenience, you may make a financial arrangement for your portion due by selecting one of our established financial options. Please ask for details of our extended payment plans. ◆ A $40 missed appointment fee may apply; see our appointment policy for full details.

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

X _____ _____
Signature of Patient or Parent if Minor Date

Revised 09/2009