PATIENT REGISTRATION

LAST NAME: _____ FIRST NAME: _____ MI: _____

ADDRESS: _____ CITY, STATE, ZIP: _____

PHONE: (___) _____-_____ SECONDARY PHONE: (___) _____-_____

DOB: _____/_____/_____ EMPLOYER: _____

e-mail_____

BILLING

PERSON RESPONSIBLE FOR BILL (*ONLY COMPLETE IF DIFFERENT FROM PATIENT*)

RELATIONSHIP TO PATIENT: (CHECK ONE): ( ) SELF ( ) SPOUSE ( ) PARENT

NAME: _____ DOB: _____/_____/_____

SOCIAL SECURITY #: _____ - _____ - _____ ADDRESS: _____

PHONE: (___) _____-_____

LIST ANY DEPENDANTS:

NAME	DOB	RELATIONSHIP

TOTAL DUE $_____

METHOD OF PAYMENT (CHECK ONE): ( ) CASH ( ) CHECK ( ) CREDIT/DEBIT CARD

( ) MASTERCARD ( ) VISA ( ) AMERICAN EXPRESS ( ) DISCOVER

CREDIT/DEBIT CARD #: _____ EXP: _____ SIGNATURE_____

PLEASE READ DISCLAIMER AND SIGN BELOW:

Using Quality Dental Plan (QDP), our office offers significant savings to patients in regards to dental services. Furthermore, understand the benefits, limitations, exclusions, and requirements of this plan and agree to the following:

- Fees for dental services are due when rendered; and
- Fees for prosthodontic (dentures) and cast restorations (crowns, in-lays, on-lays, veneers) are due at t preparation/impression visit.

If I, _____ choose not to pay at the time of service or not have a financial arrangement in place, I shall be billed t customary fees for such services. I acknowledge that I am financially responsible for payment.

SIGNATURE: _____ DATE: _____