Minor Patient Registration

Name_____
(Last Name) (First Name) (Initial)

Address_____ **City**_____ **State**_____ **ZIP**_____

Sex M F **Date of Birth**___/___/____ **Parents Marital Status** Married / Divorced / Separated / Widowed

Patient resides w/Both Parents / Mother / Father / other____ **Phone #**_____

Father's Name_____ **Soc. Sec. #**_____

Address_____ **City**_____ **State**____ **ZIP**:_____

Employer_____ **City** _____ **Occupation**_____

Mother's Name_____ **Soc. Sec #** _____

Address _____ **City** _____ **State** ____ **ZIP** _____

Employer_____ **City** _____ **Occupation**_____

In Case of Emergency Contact_____ **Day Phone #**_____
(Relationship)

Dental Insurance Information

Must be Fully Completed for our Office to Accept Your Dental Insurance

List Primary Dental Insurance below: *Patient has Secondary Dental Insurance? Yes / No*

Employee_____ **SSN/ID #**_____

Subscriber Date of Birth: _____/_____/_____

Employer:_____

Address_____ **City**_____ **State**_____ **ZIP**_____ **Insurance**

Co. Name_____ **Group Number**_____

Address_____ **City**_____ **State**_____ **ZIP**_____

Insurance Co. Phone #_____ **Patient's Relationship to Employee** Child

Insured's Signature_____

INSURED PATIENTS: In order for us to accept your dental insurance the above insurance information must be complete and verifiable. For patients who do not provide complete insurance information, payment is due in full at the time of service. Please note dental insurance rarely covers 100% of your treatment costs. Most plans claim to cover root canal therapy at 80%; however, due to UCR (usual, customary, and reasonable charges) levels the actual dollar amounts are closer to 66%. Because of this we request that 1/3 of your treatment fee be paid at time of treatment, unless otherwise specified. **Any remaining balance** (after insurance payment) **is due in full upon notification by statement.** You are ultimately responsible for the entire fee, regardless of your insurance coverage. Denial of benefits, surpassed annual maximum benefit, fees above UCR levels, or Managed Care stipulations will not cause dismissal of incurred fees. Outstanding insurance balances of 90 days will be reassigned to the patient, with payment required within 10 days. Balances may be financed through credit cards. For Delta Dental insured patients, **payment is due in full at time of treatment**. Delta Dental pays benefits directly to the subscriber, not the provider of service.

Patient's Parent initials

NON-INSURED PATIENTS: For those patients without dental insurance, payment is due in full at the time of service. Payment made in the form of cash, personal check, *MasterCard, Discover* or *VISA* is usually accepted.

Patient's Parent initials

FEES: Treatment fees discussed with patients prior to consultation represent an estimate only. A consultation fee may be charged in addition to treatment fees. The patient agrees to be financially responsible for broken appointment fees, fees associated with NSF penalties and legal fees necessary for collection of delinquent accounts. Outstanding balances over 30 days will be subjected to a finance charge of 18%APR.

If root canal treatment is started and not completed, a portion of the quoted fee will be assessed at Dr. Moyer's discretion.

Patient's Parent initials

Today's Payment will be by: **Cash /Check** **Visa/MasterCard/Discover**

The patient's parent/legal guardian assumes full financial responsibility for any fees incurred, despite any insurance coverage. I have read, understand and agree to the provisions of the financial policies. I authorize release of all my treatment and personal information for the purpose of filing insurance claims and/or treatment by other designated health care providers.

Parent / Guardian's Signature_____ **Date**_____