Craig Rothfusz, DDS
Registration Form

If you were referred to our office, whom were you referred by?
_____

Date _____

PERSONAL INFORMATION

Patient's Name _____Birthdate _____
Person Responsible for Account _____Relation to Patient _____
Occupation _____Social Security No. _____
Mailing Address _____City_____ State _____Zip _____
Home Phone _____Cell Phone _____ Work Phone _____
Email _____ Best Contact Method _____

DENTAL INFORMATION

Last Dental Examination_____ Last Dental X-Rays_____ Dentist's Name_____

INSURANCE INFORMATION

Policyholder _____ Policyholder's Birthdate _____
Dental Insurance Name _____ID No._____
Group/Plan No. _____Phone No._____
Insurance Mailing Address _____City _____ State _____ Zip_____
Employer_____

CONSENT FOR SERVICES / ASSIGNMENT & RELEASE

As a condition of your treatment by this office, financial arrangements must be made in advance. This Practice depends upon payment from its patients for the costs incurred for their care, and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in full at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this Practice cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1.5% per month (18 % per annum) on the unpaid balance will be charged on all accounts exceeding thirty (30) days, regardless of whether or not my insurance has paid.

I understand that any fee estimate provided by this office for my dental care can only be extended for a period of ninety (90) days from the date the treatment plan has been prepared, and that estimates are not a guarantee of actual services and fees incurred.

In consideration for the professional services rendered to me or at my request by the Dentist, I agree to pay the reasonable value of these services to the Dentist or his assignee at the time these services are rendered. I agree that the reasonable value of said services shall be as billed and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I acknowledge that I am responsible for informing the Dentist about any changes in my health history prior to treatment. I understand that my health history information will be used as necessary for diagnoses or treatment.

I understand that antibiotics may reduce the effectiveness of birth control.

I grant my permission to you or your assignee to telephone me at home or at my work to discuss matters related to this form.

I authorize the Dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my spouse, my child, or me 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 for dental group 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 to my dependents, my spouse or myself.

Military only: I give my permission for you to talk to my superiors if I am delinquent in paying my account.

I HAVE READ THE ABOVE CONDITIONS OF TREATMENT AND PAYMENT AND AGREE TO ABIDE BY ITS CONTENT

Signature of Patient, Parent or Guardian _____ **Date** _____