Jeffrey D. Carl, DMD PC

PATIENT REGISTRATION
(PLEASE PRINT)

Date:________________

Patient:____
Last Name First Name Middle Initial Preferred Name

Street Address:____________________City:________________ State:______________Zip:__________

E-mail:________________Home Ph:(___)__________Cell Ph.:(___)__________Work Ph:(___)__________

Sex: ☐ M ☐ F Age: _____ Birthdate: ________________ ☐ Married ☐ Widowed ☐ Single ☐ Minor
☐ Separated ☐ Divorced ☐ Partnered for ___ years.

PERSONS RESPONSIBLE FOR ACCOUNT

Name:____________________________Birthdate:______________ Home Ph.: (___) ______________

Address:____________________________City:______________State:______________Zip:__________

Occupation: ____________________SS #:____________________Work Ph: (___) __________ Ext.:________

Employer: __________________________Years Employed:____________ Driver's License #: ______________

Name:____________________________ Birthdate:______________ Home Ph.: (___) ______________

Address:____________________________City:________________ State:______________Zip:__________

Occupation: ____________________SS #:____________________Work Ph: (___) __________ Ext.:________

Employer: __________________________Years Employed:__________Driver's License #: ______________

PRIMARY INSURANCE

Subscriber Name:______________________ Birthdate:________________Dependent Coverage ☐ Yes ☐ No

Subscriber Address:____________________________________SS #: ______________________

Ins.Co:____Employee ID#:____________________

Ins. Co. Address:____

Ins. Co. Phone #:_____________________________________Group #:_______________________

SECONDARY INSURANCE

Subscriber Name:______________________ Birthdate:________________Dependent Coverage ☐ Yes ☐ No

Subscriber Address:____________________________________SS #: ______________________

Ins.Co:____Employee ID#:____________________

Ins. Co. Address:____

Ins. Co. Phone #:_____________________________________Group #:_______________________

GETTING TO KNOW YOU

Who were you referred by?____

List family member(s) or relative(s) who are patient(s) at our office:______________________________

Person to contact for emergency: ________________________________Ph.: (___) ______________

Closest relative not living with you:____

Address: ____Ph.: (___) ______________

MINOR / CHILD CONSENT

I am the parent, guardian, or personal representative of **(Please Print Name of Minor / Child):**______________________ and there are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize the dental staff to perform necessary dental services for the child named above, including but not limited to x-rays, and administration of anesthetics, which are deemed advisable by the doctor, whether or not I am present when the treatment is rendered. __________ **Initial**

- Over -

TO OUR PATIENTS REGARDING PAYMENT AND APPOINTMENTS

1. Payment is due at time of treatment. We accept Cash (includes money orders and personal checks), VISA, Mastercard, American Express, CareCredit, and Citi Healthcard.

2. If your budget requires monthly payments, please discuss CareCredit or Citi Healthcard with our financial coordinator in the business office, before your appointment.

3. If you have dental insurance coverage, we ask you to pay any deductible and/or co-payment at the time of treatment.

FOR FIRST TIME PATIENTS -

If you have insurance, please provide us with complete information, including the address of your insurance and the birthdate of the insured on the back of this form. Bring your insurance card with you and we will photocopy it. We will bill your insurance as a courtesy to you. Please remember that your insurance is not our insurance. Any questions concerning your policy should be directed to your insurance company. We ask that you assign all insurance benefits directly to Jeffrey D. Carl, D.M.D., P.C. If you need further assistance, please call us. We are very happy to help you in any way possible.

If you do not have dental insurance, our office policy is that payment in full must be made at the time of treatment. If there is a need to make monthly payments, financial arrangements must be obtained, in advance, from CareCredit or Citi Healthcard. Our business office will assist you with these financing options. For accounts that go beyond 60 days a 1.5% monthly interest charge (18% per annum) will be assessed.

Our office policy is to obtain a credit report for financial purposes. Payment in full, at the time of treatment, will allow for 5% savings when paid at time of treatment with cash or check. We also offer a senior discount of an additional 5% for patients who are 65 or older.

You have my permission to request medical and dental records, (including X-rays), from any previous provider. _____**Initial**

I acknowledge that I have received a copy of Dr. Carl's Notice of Privacy Practices. _____**Initial**

APPOINTMENTS:

You may make appointments by calling (**541-926-6089**) Mon-Thur 8:00 am to 5 pm. Please call to cancel or reschedule 24 hours in advance or you will be charged the customary fee of $50.00 per hour for a missed appointment. Your doctor sets aside time especially for you. Insurance companies will not cover or reimburse missed appointment charges.

We appreciate you for entrusting your dental health care to us. Thank you.

Signature_________________________________ **Date** _______________________