PATIENT REGISTRATION

Office of Dr. Mauro Nunes

Today's Date: ____ /____ / _____

Name: _____ Date of Birth: ____ /____ / _____
(Last) (First) (Middle) (Preferred)

Address: _____ City/State: _____ Zip: _____

Home Phone: (_____) _____ - _____ Cell Phone: (_____) _____ - _____ EMAIL: _____

Employer: _____ Work Phone: (_____) _____ - _____

Marital Status: _____ Spouse/Partner: _____

Referred by: _____

RESPONSIBLE PARTY (IF *SAME AS ABOVE, CHECK HERE:* ❑)

Name: _____ Relationship to Patient: _____

Address: _____ City/State: _____ Zip: _____

Home Phone: (_____) _____ - _____ Cell Phone: (_____) _____ - _____ EMAIL: _____

Drivers License Number: _____ Date of Birth: ____ /____ /_____

Employer: _____ Work Phone: (_____) _____ - _____

PAYMENT POLICY

It is our experience that the best practice-patient relationships are maintained when there is complete understanding of the treatment to be rendered and the associated charges. Therefore, please feel free to discuss all fees prior to treatment. We expect patients to pay all fees, or some anticipated portion of the fees if insurance is involved, at the time services are rendered. As a courtesy, we will submit insurance for you and accept assignment of benefits. However, we cannot accept the responsibility for collecting insurance payments or for negotiating a disputed claim. While we will assist you with providing all of the information we have about your treatment to the insurance company, please remember that insurance is a contract between you and the insurance carrier. Ultimately, you are responsible for payment of all fees. If you have any questions or concerns about the policy, please discuss them with us prior to treatment. For your convenience, we accept cash, check or Visa/Mastercard.

DENTAL INSURANCE (Note: If you have secondary insurance, please inform our office manager.)

Name of Insured: _____ Relationship to Patient: _____

Date of Birth: ____ /____ /_____ Social Security Number: _____ - _____ - _____ Insurance ID Number: _____

Insured's Employer: _____ Work Phone: (_____) _____ - _____

Insurance Company: _____ Phone: (_____) _____ - _____ Group Number: _____

Insurance Company Address: _____ City/State: _____ Zip: _____

I authorize release of any information relating to dental claims. I understand that my dental insurance may pay less than the actual fees for the services rendered and agree to be responsible for the full payment of all dental services provided on my behalf or that of my dependents. I authorize and request my dental insurance company to make payments otherwise payable to me to be made directly to this practice.

Signature: _____ Date: _____