Patient Registration

Terrence E. Robbins, DMD, Inc

Patient Information

Name: _____ _____ M F
Last Name First Name MI Sex

Date of Birth: _____/_____/_____ SS# _____

Address: _____
Street City State Zip

Phone #'s: Home (_____)_____ Work (_____)_____ Cell (_____)_____

Email Address: _____ Employer: _____

Emergency Contact: _____ Phone # (_____)_____

Relationship _____ Whom May We Thank For Referring You _____

Responsible Party: The person who is responsible for this account

Name: _____ _____
Last Name First Name Relationship

Address: _____
Street City State Zip

Phone #'s: Home (_____)_____ Work (_____)_____ Cell (_____)_____

SS# _____ Employer: _____

Insurance Agreement

Patients with dental insurance understand that all services are charged directly to the patient and that he or she is ultimately responsible for payment of all services. It is your responsibility to notify us of any change in your insurance coverage or benefits to insure timely submission of claims. Our office will gladly prepare the insurance forms to assist in obtaining payment from insurance companies and will accept payments directly to our office. Insurance benefit calculations provided by our office are done as a courtesy and are not a guarantee of coverage. Denied services, payments that differ from the estimated payment or claims not paid within 60 days of submission are your responsibility. If a more definitive estimate of your insurance benefits is desired please request a submission for Predetermination of Benefits before treatment begins.

Financial Policy

Payment for services provided by Dr. Robbins is due the day services are rendered, unless prior arrangements have been made. If you are interested in learning more about our payment options please ask our expert staff before treatment begins. All balances not paid as agreed are subject to 1 ½ % per month (annual rate 18%) until paid in full.

_____
Signature of Patient (over 18 years of age) or Legal Guardian (if under 18 years of age) Date