

Name \_\_\_\_\_ Male  Female   
 (last) (first) (initial)  
 Single  Married  Separated  Divorced  Widowed  Drivers License \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Social Security # \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Business Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Pager \_\_\_\_\_  
 E-mail address \_\_\_\_\_ Web site address \_\_\_\_\_  
 Patient's Employer \_\_\_\_\_ Spouse's Name \_\_\_\_\_  
 Spouse's Employer \_\_\_\_\_ Spouse's work phone \_\_\_\_\_  
 Closest Relative not living with you \_\_\_\_\_ Phone \_\_\_\_\_  
 Whom may we thank for referring you to us? \_\_\_\_\_

**DENTAL INSURANCE COVERAGE**

Name of Insurance \_\_\_\_\_ Company Employee Name \_\_\_\_\_

**FINANCIAL POLICY**

We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial Policy, or your responsibility.

All patients must complete our "Patient Information Form" before seeing the doctor.

**FULL PAYMENT IS DUE AT TIME OF SERVICE.**

We accept cash, checks, Visa, Mastercard, America Express, Discover and debit cards. We do not accept out of state checks.

**ADULT PATIENTS OR MINORS ACCOMPANIED BY AN ADULT**

Adult patients are responsible for full payment at time of service. The adult accompanying a minor, and his/her parents or guardians.

**MISSED APPOINTMENTS**

Unless cancelled at least 48 hours in advance, our policy is to charge a minimum of \$25.00 for a missed appointment. Please help us serve you better by keeping scheduled appointments.

**REGARDING INSURANCE**

In our office we use only high tech materials and procedures without regard for your insurance company benefits. In other words, we will not compromise the quality of our dentistry.

Insurance is a contract between you and your insurance company. We are NOT a party to this contract, in most cases. (We will inform you if we are a party to your insurance contract, and will handle your claims according to our agreement with the insurance company, if one exists.) We file insurance claims as a courtesy to our patients. We will not become involved in disputes between you and the insurance company regarding deductibles, co-payments, covered charges, secondary insurance, "usual and customary" charges, etc., other than to supply factual information as necessary.

If you and/or your insurance company has not paid the FULL BALANCE within 60 days, late payment charges of 1.5% per month (minimum \$3.00) will be added to your account. If your insurance company pays more than the balance due, we will send a refund check to you immediately.

**RETURNED CHECKS**

We reserve the right to charge our fee for a normal office visit for all returned checks. In the case of collection procedures we will add to your final bill all expenses generated by this action (such as collection agency fees, attorney fees, calls, mail, etc.).

**AUTHORIZATION TO PAY BENEFITS TO DENTIST and RELEASE OF INFORMATION**

I hereby authorize payment directly to Dr. Florian Braich, DDS, PA, of the benefits otherwise payable to me.

I authorize release to my insurance company of any information relating to my dental claims.

I understand that I am responsible for all charges for dental treatment.

Responsible Party Signature \_\_\_\_\_ Date \_\_\_\_\_

**REGISTRATION**

