CENTER ONE
DENTAL ASSOCIATES
Family, Implant & Cosmetic Dentistry

9880 Bustleton Avenue Suite 213 Philadelphia, PA 19115 215-673-4888

PATIENT REGISTRATION

Patient Name: _____ ____ Married ____ Divorced _____ Single ____ Other

Address: _____ City: _____ State: _____ Zip: _____

Home #: _____ Cell #: _____ Email Address: _____

Date of Birth: _____ Employer: _____

Patient SS #: _____ Work #: _____

Spouse/Guardian Name: _____ Policy Holder: ___ Yes __ No

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Employer: _____

Home #: _____ Cell #: _____ Email Address: _____

Spouse SS # if policyholder: _____ Work #: _____

Referral Information

Whom may we thank for referring you to our office?

Referring Doctor/Office: _____ Referring Patient : _____

Referring Family Member: _____ __Drive By __ Lobby Sign __ Google __ Facebook __ Other

Pharmacy Information

Pharmacy Name: _____ Pharmacy Phone #: _____

Pharmacy Address: _____

Emergency Contact

Name: _____ Phone Number: _____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in 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 at the time services are performed. The office will 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 dental office cannot render services on the assumption that the insurance company will pay our charges in full. We will provide you with an estimate in the hopes of being transparent about the investment in your treatment. A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 90 days unless previously written financial arrangements are satisfied. I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient's examination. All fees associated with collections and/or Attorney's costs for collecting past-due balances will be your responsibility. The undersigned hereby authorizes the doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to diagnose the patient's needs thoroughly. I grant you or your assignee permission to telephone me at home and leave a message. I understand that it is my responsibility to advise your office of any changes in the information contained in this form.

I have read the above conditions of treatment and payment and agree to their content.

Patient Name: _____ Patient Signature: _____ Date: _____