WELCOME

Account Registration

Patient Information: **Responsible Party other than Patient:**

NAME	**NAME**
Address	Address
City, State	City, State
Zip Code	Zip Code
Home phone	Home phone
Cell phone	Cell phone
Work phone	Work phone
E mail	E mail
Birth date Sex	Birth date Sex
Social Security Number	Social Security Number
Name and phone of nearest relative/emergency contact	Name and phone of nearest relative/emergency contact
EMPLOYER	**EMPLOYER**
DENTAL INSURANCE	**DENTAL INSURANCE**

Whom may we thank for this referral? ___another patient_____

___insurance company ___web site

___yellow pages ___mailing

___other_____

METHOD OF PAYMENT: CASH/CREDIT CARD_____ INSURANCE____

As a courtesy, we can file most insurance claims for you. Please bring your insurance plan information with you on your first visit. Please notify us if there are ever changes to your insurance. We will work with you to ensure that you receive the maximum benefits to which you are entitled. Please remember that the contract itemizing dental benefits is between you and your insurance carrier. If your dental plan does not pay within 60 days of treatment, you must pay any outstanding balance and seek reimbursement from your dental insurance carrier.

I AUTHORIZE RELEASE OF ANY INFORMATION REQUIRED IN THE COURSE OF EXAMINATION AND/OR TREATMENT. I PERMIT PAYMENT OF INSURANCE BENEFITS DIRECTLY TO THE DENTIST FOR HIS/HER SERVICES RENDERED. I RECOGNIZE AND ACCEPT RESPONSIBILITY FOR SERVICES NOT COVERED BY INSURANCE BENEFITS.

RESPONSIBLE PARTY SIGNATURE_____DATE_____

I have been informed of Mequon Dental Group's adherence to required Privacy Practices as dictated by the **Health Insurance Portability & Accountability Act (HIPAA).**

Patient : (or guardian if minor)

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(signature) (date)