Horizon West Dental

PATIENT REGISTRATION

Patient Name: ____ Preferred Name:______________________
First Middle Initial Last

Address:____ Date of Birth:_________________________

City:____________________________________ State:___________________ Zip:___________________________

Sex: M/F Family Status: ☐ Married ☐ Single ☐ Child ☐ Other: _________________________

Home Phone:_______________________ Cell Phone:______________________ Other:_____________________

Soc. Sec. No.:_________________________ E-mail Address:____

Employer:_____________________________Occupation:_________________ Work no:___________________

Spouse/Emergency
Contact:________________________________ Soc. Sec. No.:__________________ Phone:___________________

Person Responsible for
Charges:________________________________ Soc. Sec. No.:__________________ Phone:___________________

How will charges be taken care of today ☐ CASH ☐ CREDIT CARD ☐ CHECK

How did you hear about us? ☐ RADIO ☐ PAPER ☐ WEBSITE ☐ DIRECT MAIL ☐ FACEBOOK
☐ INSURANCE ☐ REFERRAL ☐ OTHER ____________________

***Who may we thank for referring you? ____

HIPAA ACKNOWLEDGEMENT

I understand that I may inspect or copy the protected health information described by this authorization.
I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and payment for my healthcare will not be affected if I refuse to sign this form.
I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

By signing, I understand the above information and agree with its contents, and this will serve as my electronic signature for the HIPAA Disclosure Form.
Patient's Signature:____ Date:________________________

INSURANCE

Primary Dental Insurance:___________________________ Group No.:_________________________________

Policy Holder Name:____________________________________ ID#:___________________________________

Policy Holder's Date of Birth:_______________________ Relationship to you:_____________________________

Policy Holder's Address:____

City State/Zip Code

Secondary Dental Insurance:__________________________ Group No.:_________________________________

Policy Holder Name:____________________________________ ID#:___________________________________

Policy Holder's Date of Birth:_______________________ Relationship to you:_____________________________

Policy Holder's Address:____

City State/Zip Code

I understand and agree that dental insurance policies are an arrangement between an insurance carrier and me. I authorize assignment of my insurance benefits (if applicable) directly to Horizon West Dental and the use of electronic signature on all insurance submissions. I authorize Horizon West Dental to release and/or request records to or from other providers as necessary. I understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. An outstanding balance that is 90 days and older will be assessed a monthly service fee of $5.00 or interest charge of 16% APR depending on the amount of the balance. This policy is subject to change.

I hereby authorize the Dentist to examine and treat my condition as he/she deems appropriate and I give authority for these procedures to be performed. **I also agree that I am responsible for all bills incurred by me at this office whether or not paid by insurance.** The Dentist will not be held responsible for any pre-existing Dental conditions nor for any medical diagnosis.

Patient's Signature:____ Date:____________________________

Guardians
Signature Authorizing Care:______________________________________ Date:____________________________