Patient Registration Form

Patient Name_____ **Date of Birth**_____

Guardian, if under age 18 _____ **Relationship to patient** _____

Address_____

_____

Phone_____ **E-mail**_____

1. ☐ Yes, *I provide consent to Cardone Family Dental to use my cell phone number to text regarding appointments. I understand that I can withdraw my consent at any time. My cell phone number is (include area code)*

_____ _____*(initial)*

Employer_____

Address_____

How did you hear about the office? _____

Dental Insurance Information

Subscriber Name_____ **Subscriber ID#**_____

Subscriber SSN#_____ **Subscriber Date of Birth**_____

Insurance Carrier Name_____ **Group Name and Number**_____

Additional Dental Coverage

Subscriber Name_____ **Subscriber ID#**_____

Subscriber SSN #_____ **Subscriber Date of Birth#**_____

Insurance Carrier Name_____ **Group Name and Number**_____

Billing and Payment of Fees

Insurance co-payments, deductibles, and deposits on major work are due at the time of service. Any remaining monies are due at the time the treatment is completed. We accept cash, check, MasterCard, Visa, American Express and Discover. For those patients with financial restrictions we offer funding through a private financing company, Care Credit. Missed or cancelled appointments will be charged a fee of **$50.00** if not cancelled within 24 hours notice for general appointments and 48 hours notice for specialty appointments.

Your signature provides a release of your dental benefits and any dental information needed to process your claim. It also indicates your acceptance of our office policies and financial responsibility.

Signature_____

Date_____