

# Patient Registration Information

**CONFIDENTIAL**

Date: \_\_\_\_\_

Patient #: \_\_\_\_\_

(For Office Use Only)

Name: \_\_\_\_\_  
First MI Last

Name You Prefer: \_\_\_\_\_

## Welcome to The Smiling Place!

**Thank you for selecting our dental health care team. Please fill out this form completely in ink. If you have any questions or concerns, please do not hesitate to ask for assistance - we will be happy to help!**

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Home Phone:( ) \_\_\_\_\_ Work Phone:( ) \_\_\_\_\_  
Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Other Phone:( ) \_\_\_\_\_ May we contact you here? Yes / No

Are you:  Minor  Single  Married  Divorced  Widowed  Separated  
You or your parent's employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Bus. Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Spouse or parent's name: \_\_\_\_\_ Employer: \_\_\_\_\_ Bus. Phone: ( ) \_\_\_\_\_  
If you are a student, name of school/college: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_  
How did you hear about us? \_\_\_\_\_  
Person to contact in case of an emergency: \_\_\_\_\_ Phone:( ) \_\_\_\_\_

### Responsible Party

Name of person responsible for account, if other than patient: \_\_\_\_\_  
Relationship: \_\_\_\_\_  
Address: \_\_\_\_\_ Home Phone:( ) \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_ Soc.Sec.#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Driver's License #: \_\_\_\_\_ Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Employer: \_\_\_\_\_ Bus. Phone:( ) \_\_\_\_\_  
Is this person a current patient:  Yes  No

### Insurance Information

Name of insured: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_  
Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Soc.Sec.#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date employed: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Employer: \_\_\_\_\_ Bus. Phone:( ) \_\_\_\_\_  
Address of employer, City, State, Zip: \_\_\_\_\_  
Insurance Company: \_\_\_\_\_ Group#: \_\_\_\_\_ Company#: \_\_\_\_\_

### Additional Insurance

Do you have any additional insurance?  Yes  No If yes, complete the following:  
Name of insured: \_\_\_\_\_ Relationship to you: \_\_\_\_\_  
Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Soc.Sec.#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date employed: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Name of employer: \_\_\_\_\_ Bus. Phone: \_\_\_\_\_  
Address of employer, City, State, Zip: \_\_\_\_\_  
Insurance Company: \_\_\_\_\_ Group#: \_\_\_\_\_ Company #: \_\_\_\_\_

## Office Policies

1. Acquainting the patient with our office and staff.
2. Taking necessary X-rays.
3. Visual examination of the mouth, head, and neck region.
4. Use of other aids which may be necessary in order to make an accurate diagnosis.
5. A diagnosis is made and the most satisfactory treatment plan will be discussed with you.
6. Sometimes a separate consultation appointment (without charge) may be necessary to discuss in detail the results of the initial examination.
7. **If you are covered by dental insurance, it is our policy to bill your insurance carrier as a courtesy to you. However, you are responsible for the entire balance including local taxes.**
8. Appointment can be easily made with our Receptionist; cancellations should be made at least forty-eight (48) hours prior, to avoid a **broken appointment charge** of eighty-two dollars and fifty cents minimum.
9. I understand and accept what I have read.

X \_\_\_\_\_  
Signature of patient or parent if minor

\_\_\_\_\_  
Date

## Authorization, Release and Arrangement to Pay for Services Rendered

1. I authorize the Dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such dental care to third party payor's and/or other health practitioner's.
2. I authorize and hereby request my insurance company to pay directly to the dentist, insurance benefits otherwise payable to me.
3. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment for all services rendered on my behalf or on behalf of my dependents.
4. I authorize THE SMILING PLACE - (Dr. Benson H. Araki, D.D.S.) to obtain my credit report from Credit Bureau of the Pacific, Inc. and to report your credit experiences with me, including obtaining a current credit report upon receipt of this application and subsequently for the purpose of account updates renewal, potential employment or extension of credit.

X \_\_\_\_\_  
Signature of patient or parent if minor

\_\_\_\_\_  
Date

## Financial Arrangements

For your convenience, we offer the following methods of payment. Please check the option which you prefer. Payment is requested, in full, after each appointment unless a **Financial Arrangement** is made in advance. Please do not hesitate to ask if you have any questions.

\_\_\_\_\_ Cash  
\_\_\_\_\_ Credit Card

\_\_\_\_\_ Personal Check  
\_\_\_\_\_ Visa/Master Charge

## Late Charges

If I do not pay the entire new balance within 25 days of the monthly billing date, a late charge of 1.5% on the balance then unpaid and owed will be assessed each month. I realize that failure to keep this account current may result in you unable to provide additional dental services except for dental emergencies or where there is a prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.

X \_\_\_\_\_  
Signature of patient or parent if minor

\_\_\_\_\_  
Date

**Thank you for filling out this form completely. The information you have provided will help us serve your dental health care needs more effectively and efficiently. If you have any questions at any time, please ask us, we are always happy to help.**