

### Patient Registration

Patient Name \_\_\_\_\_ Date \_\_\_\_\_  
Spouse/Parent's Name \_\_\_\_\_  
Street Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Email \_\_\_\_\_  
Birthdate \_\_\_/\_\_\_/\_\_\_ Social Security Number \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_  
Driver's License Number \_\_\_\_\_  
Sex: Male \_\_\_ Female \_\_\_ Marital Status: M\_\_\_ S\_\_\_ D\_\_\_ W\_\_\_  
Employer \_\_\_\_\_ Work Phone \_\_\_\_\_  
If Student, School name \_\_\_\_\_  
Referred by \_\_\_\_\_

### Dental Insurance or Guarantor's Information

If you do not have insurance, please complete the first four lines with information about the person's who are financially responsible for your account.

Guarantor/Insured's Name \_\_\_\_\_  
Employer \_\_\_\_\_  
City \_\_\_\_\_ Work Phone \_\_\_\_\_  
Birthdate \_\_\_/\_\_\_/\_\_\_ Social Security Number \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_  
Sex: Male \_\_\_ Female \_\_\_  
Relationship to Patient : Self \_\_\_ Parent \_\_\_ Spouse \_\_\_ Other \_\_\_  
Name of Insurance Company \_\_\_\_\_  
Address \_\_\_\_\_  
Phone # \_\_\_\_\_ Group # \_\_\_\_\_ Local # \_\_\_\_\_

2<sup>nd</sup> Guarantor/Insured's Name \_\_\_\_\_  
Employer \_\_\_\_\_  
City \_\_\_\_\_ Work Phone \_\_\_\_\_  
Birthdate \_\_\_/\_\_\_/\_\_\_ Social Security Number \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_  
Sex: Male \_\_\_ Female \_\_\_  
Relationship to Patient : Self \_\_\_ Parent \_\_\_ Spouse \_\_\_ Other \_\_\_  
Name of Insurance Company \_\_\_\_\_  
Address \_\_\_\_\_  
Phone # \_\_\_\_\_ Group # \_\_\_\_\_ Local # \_\_\_\_\_

**Financial Agreement with Steven M. Chew, D.D.S.**

I authorize any dental insurance company, insuring me and my family members, to pay Steven M. Chew, D.D.S. for treatment or services rendered. The dental provider has my permission to release to my dental insurance company whatever information is required by them to satisfy my claims.

I hereby acknowledge responsibility for any and all dental charges billed to me and my family. I further acknowledge that dental and health insurance is a method of reimbursing for dental fees and is not a substitute payment. The dental provider shall bill my insurance company as an accommodation only. I am not only responsible for payment, but also for following up on the billing of my insurance company to make sure that they have been billed for by Steven M. Chew, D.D.S. On each visit I will pay the portion of my bill not covered by dental insurance, unless other arrangements are made with Steven M. Chew, D.D.S. or one of his office staff members. If my insurance company has not paid after 30 days, I am liable for the unpaid portion in full.

If I do not have insurance, I recognize that payment of the balance in full is expected at the conclusion of each visit, unless other arrangements are made with Steven M. Chew, D.D.S. or one of his office staff members.

If my financial obligation is not met, I agree to the following. If this account is assigned to Collections, an attorney or small claims court, I shall be responsible for payment of collection costs, attorney's fees and court costs. Any returned checks is subject to a \$20 service charge. A late charge in the amount of 1.5% per month (18% APR) or a minimum charge of \$1.50 can be assessed on any balance over 30 days.

I hereby authorize Steven M. Chew, D.D.S. to obtain a Consumer Credit Report on me from any credit reporting agency as deemed necessary by said dental provider.

A photostatic copy of this agreement can be considered as an original.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date