Patient Registration

Please Complete the Following Confidential Information

Name_____ Preferred Name_____
First Middle Last

Birthdate _____ Social Security Number_____

Single_____ Married_____ Separated_____ Widowed_____ Divorced_____

Home Address: _____
Street City State Zip Code

Phone: Home_____ Work_____ext._____ Cell/Mobile_____

Employer_____ Occupation_____

Business Address:_____
Street City State Zip Code

In case of an emergency, please contact _____ Relationship to Patient_____

Phone: Home_____ Work_____ext._____ Cell/Mobile_____

Person responsible for this account? _____ Relationship to Patient_____

Whom may we thank for recommending you to our office?_____

Dental Insurance Information

Insurance Company:_____ Group Number:_____

Claim Address:_____ Insurance Co. Phone Number:_____

Policy Holder's Name:_____Relationship to Patient:_____Employer:_____

Policy Holder's Social Security Number:_____and Date of Birth:_____

Office Policies

- Payment is due in full at the FIRST visit. If you have insurance, we will file your claim to pay you directly
- Patients with Delta Dental Insurance must pay in full at time of service and we will file the claim for you. Delta pays you directly.
- This office does not file secondary insurance claims.
- You are responsible for all charges regardless of ESTIMATED insurance coverage.
- A finance charge of 1.5% will be applied to all accounts older than 60 days.
- There is a $25.00 charge for all returned checks.
- Davidian & Associates requires a cancellation notice of two business days prior for all sedation appointments. If this requirement is not met, then a $265.00 cancellation fee will be charged. If the appointment is canceled the morning of the appointment or after office hours the day before, then a $500.00 cancellation fee will be charged. In case of sickness, the cancellation fee will be waived upon receipt of a doctor's note confirming the contraindication of the sedation to the illness. Extreme or unusual circumstances will be reviewed on a case-to-case basis. For regular scheduled appointments, there will be a cancellation fee of $35.00 for less than 2 business days notice. We reserve time for you and by not showing up or canceling an appointment prevents others from being served.

The information I have provided is complete and accurate to the best of my knowledge. I consent to the procedures deemed necessary to diagnose my oral condition. I agree to be responsible for payment of all services rendered. I authorize a credit check should I ask for credit.

Signature_____ Date_____