Inspired Smiles
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10442 Patterson Avenue
Henrico, VA 23238

PATIENT REGISTRATION

Name: _____ Birthdate: ___/___/___ Social Security #: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____Cell Phone: _____ Gender: Male/Female
Occupation: _____ Employer: _____
Marital Status: Single / Married / Divorced / Separated / Widowed Email Address: _____
How would you prefer to be contacted by our office? Home Phone / Work Phone / Cell phone
How did you hear about our practice? _____
Emergency Contact:_____Phone:_____

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT

Name: _____ Social Security #: _____
Address (if different from above) : _____
City: _____ State: _____ Zip: _____
Home Phone: _____Work Phone: _____Cell Phone:_____
Occupation: _____ Employer: _____

DENTAL INSURANCE INFORMATION

Primary Insurance
Insurance Company Name: _____ Address:_____
Name of Policy Holder: _____ Birthdate: ___/___/___ Social Security #: _____
Policy #: _____ Group #: _____Employer:_____
Patient Relationship to Insured: Self / Spouse / Son / Daughter / Other
Secondary Insurance
Insurance Company Name: _____ Address:_____
Name of Policy Holder:_____ Birthdate: _____
Policy #: _____ Group #: _____Employer:_____
Patient Relationship to Insured: Self / Spouse / Son / Daughter / Other
Please present your insurance card for duplication

MEDICAL INSURANCE INFORMATION (if applicable)

Insurance Company Name: _____ Address:_____
Name of Policy Holder: _____ Birthdate: ___/___/___ Social Security #: _____
Policy #: _____ Group #: _____Employer:_____
Patient Relationship to Insured: Self / Spouse / Son / Daughter / Other
Please present your insurance card for duplication

CONSENT FOR SERVICES

I understand that I am financially responsible for all dental services rendered in this office for myself and my dependants regardless of dental insurance benefits. Payment is due in full at time of services rendered. Accepted forms of payment are cash, check, Visa or Mastercard. Dental insurance will be filed by the doctor's office as a courtesy, and request payments be sent to me.

I understand that a 1.5% finance charge (18%APR) may be added to my account in the event of late payments. In the event that my account is forwarded to a collection agency, I agree to pay a fee of thirty–three and one third percent (33 1/3%) of the outstanding balance as well as any and all collection agency fees, attorney's fees and court costs incurred in any legal action.

I understand that the fee estimate provided to me for my dental care is extended 30 days from the date of presentation. We kindly ask that all appointment cancellations be made at least 24 hours in advance of scheduled appointment. I understand a missed appointment fee may be assessed for all missed appointments of less than 24 hour cancellation notice.

The information on this form is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. I understand that my signature will be used as a "Signature on file" for insurance processing.

_____ _____ _____
Signature of Patient (or Legal Guardian) Date Relationship to Patient