JESSE G. HAYDEN

DMD PC

PATIENT REGISTRATION

First Name:_____Last Name:_____Middle Initial:

Preferred Name:_____

Patient is : □ Responsible Party □ Policy Holder

Address:_____ Address 2:_____

City, State, Zip:_____

Home Phone:_____ Work Phone:_____Cell Phone:_____

Sex: ○ Female ○ Male Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Birth date:_____ Social Security #:_____ Drivers Lic#:_____

E-mail: _____ □ I would like to receive email correspondences

Referred by:_____

Responsible Party: (If someone other than the patient)

First Name:_____ Last Name:_____ Middle Initial:

Address: _____ Address 2:_____

City, State, Zip:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Birth date:_____ Social Security #:_____ Drivers Lic#:_____

○ Responsible Party is Policy Holder for Patient ○ Primary Policy Holder ○ Secondary Policy Holder

Primary Insurance Information:

Name of Insured:_____ Relationship to Insured: ○Self ○Spouse ○Child ○ Other

Insurance Co: _____ Insured Employer:_____

Insured SS# or ID#: _____ Group#:_____ Insured Birthdate:_____

Secondary Insurance Information:

Name of Insured:_____ Relationship to Insured: ○Self ○Spouse ○Child ○ Other

Insurance Co: _____ Insured Employer:_____

Insured SS# or ID#: _____ Group#:_____ Insured Birthdate:_____

Authorization

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party and/or other health professionals.

Service Charge

If I do not pay the entire new balance within 30 days of the monthly billing date, a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate of 1.8% per month (or a minimum charge of $5.00 for a balance under $100.00) which is an annual percentage rate of 18% applied to the last month's balance. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

Patient or responsible party may be subject to a **$50 per hour failed appointment fee** if the appointment is broken without 24 hour notice.

X_____ Patient or Responsible Party _____ Date