DuPont Family Dentistry
975 Ross Ave. Suite #100 DuPont, WA 98327
Phone: 253 964 7000 Fax: 253 964 0345

Patient Registration
Please print patient information

Full Name:_____ Preferred Name:_____

Date of Birth:___/___/_____ Age:_____ Social Security Number:_____-_____-_____Male☐/Female ☐

Mailing Address:_____City:_____State:_____Zip:_____

Home Phone:_____ Cellular Phone:_____ Email Address:_____

Preferred Contact: Home Phone ☐ /Cell Phone☐/Email☐

Employer Information

Employer Name:_____ Occupation:_____

Work Phone:_____ Extension:_____

Responsible Party Information (if not patient)

Full Name:_____ Relationship to Patient: Spouse ☐/Parent☐/Other☐

Date of Birth:___/___/_____ Age:_____ Social Security Number:_____-_____-_____

Mailing Address:_____City:_____State:_____Zip:_____

Home Phone:_____ Cellular Phone:_____ Email Address:_____

Primary Insurance Information

Name of Insured:_____ Relationship to Patient: Spouse ☐/Parent☐/Other☐

Date of Birth:___/___/_____Age:_____ Social Security Number:_____-_____-_____

Employer Name:_____ Work Phone:_____

Dental Plan Name:_____ Phone:_____

Dental Plan Address:_____ City:_____ State:_____ Zip:_____

Member ID#_____ Group #_____

Secondary Insurance Information

Name of Insured:_____ Relationship to Patient: Spouse ☐ /Parent☐/Other☐

Date of Birth:___/___/_____Age:_____ Social Security Number:_____-_____-_____

Employer Name:_____ Work Phone:_____

Dental Plan Name:_____ Phone:_____

Dental Plan Address:_____ City:_____ State:_____ Zip:_____

Member ID#_____ Group #_____

Patient Registration

Continued

How did you hear about our dental practice ?_____

Emergency Contact

Please give us the name of a relative or friend **NOT** living in your household, who we could contact in case of an emergency.

Name: _____ Phone: (____) _____ Relationship: _____

Conditions Of Service

(please read and sign below)

Acknowledgement Of Privacy Rights:

I confirm that I have been informed of my rights to privacy regarding my protected health information, and I have been given the opportunity to review this office's *Notice of Privacy Practices* as required by the Health Insurance & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- Provide and coordinate treatment among health care providers who may be involved in my care
- Obtain payment from third-party payers for my health care services
- Conduct normal health care operations

Please name any other dependents or family members covered by this acknowledgement:

_____

Appointments:

When an appointment is scheduled, this time slot is reserved especially for you. All missed or broken appointments without a minimum of 24 hours advanced notice are subject to a $50.00 per half hour fee. To change or cancel appointments please call during our office hours, please note that our answering service will not accept appointment changes.

Payment is due at time of service.

Please be aware that accounts 60 days past due are subject to a minimum $5.00 monthly processing fee at time of billing.

For Patients with Dental Insurance Only:

For those patients with dental insurance, Dupont Family Dentistry may release information about my treatment for purposes of processing any dental claims. I would like my benefits paid directly to Dupont Family Dentistry. I understand that processing of insurance claims is a courtesy and does not relieve me of my financial obligations resulting from any treatment provided by Dupont Family Dentistry. I agree to pay any outstanding balance remaining on my account after a period of 60 days regardless of slow insurance company processing, disputed claims, employer eligibility requests, information requests, lack of eligibility or benefits, or any other delays, etc.

Dupont Family Dentistry will accept "insurance assignment" in lieu of my personal payment for a period of 60 days. After 60 days, unpaid insurance claims are due and payable by me. If I wish to file my own insurance claims, payment in full is due at time of service.

By signing below I have read and agree to the conditions of service with Dupont Family Dentistry.

Printed Name: _____ Signature: _____ Date: ____ /____ /_____

For Office Use Only We were unable to obtain the patient's signature due to the following reason:
Patient refused to sign ___ Communication barrier ___Emergency situation ___Other _____