HOW DID YOU HEAR ABOUT US? ☐ **GOOGLE** ☐ **INSURANCE PROVIDER** _____

☐ **BILLBOARD** ☐ **REDWOOD WEBSITE** ☐ **YELLOWPAGE ONLINE** ☐ **FRIEND** ☐ **RELATIVE** ☐ **OTHER**_____

WHO IS RESPONSIBLE FOR THIS ACCOUNT? *Circle one:* MR MRS MS MISS DR **NAME:**

ADDRESS:	E-MAIL ADDRESS:
CITY, STATE:	BIRTH DATE: / / SEX: M F
ZIP CODE:	SOCIAL SECURITY NO.: - -
HOME PHONE:	**EMPLOYER:**
WORK PHONE:	EMERGENCY CONTACT:
CELL #:	NAME _____
Method of Payment: Insurance ☐ Cash/Check ☐ Credit Card ☐	PHONE # _____

DENTAL INSURANCE PRIMARY COVERAGE

EMPLOYEE NAME:	
ADDRESS:	
CITY, STATE:	
ZIP CODE:	
HOME PHONE:	
WORK PHONE:	
BIRTH DATE: / / SEX: M F	
SOCIAL SECURITY NO.: - -	
EMPLOYER:	
INSURANCE NAME:	
INS. ADDRESS:	
GROUP # OR LOCAL #:	
SUBSCRIBER #:	

DENTAL INSURANCE SECONDARY COVERAGE

EMPLOYEE NAME:	
ADDRESS:	
CITY, STATE:	
ZIP CODE:	
HOME PHONE:	
WORK PHONE:	
BIRTH DATE: / / SEX: M F	
SOCIAL SECURITY NO.: - -	
EMPLOYER:	
INSURANCE NAME:	
INS. ADDRESS:	
GROUP # OR LOCAL #:	
SUBSCRIBER #:	

MEDICAL INSURANCE PRIMARY COVERAGE

INSURANCE NAME:	
INS. ADDRESS:	
GROUP #:	
SUBSCRIBER #:	

MEDICAL INSURANCE SECONDARY COVERAGE

INSURANCE NAME:	
INS. ADDRESS:	
GROUP #:	
SUBSCRIBER #:	

The account holder is responsible for all account balances older than 90 days, regardless of insurance coverage or reimbursement status. All account balances 90 days and older will accrue a late payment charge of 2% monthly.

If account enters collection, a 21% collection fee will be added to the balance.

Your insurance policy is a contract between you and your insurance company. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. Payment is due at time of service. We accept cash, checks and most major credit cards.

Any missed appointments without 24 hours notice, except in an emergency, will result in a charge to the patient. These charges are due and payable within 30 days.

I authorize release of any information required in the course of examination and/or treatment. I permit payment of insurance benefits directly to the dentist for services rendered. I recognize and accept responsibility for payment of services not covered by insurance benefits.

RESPONSIBLE PARTY SIGNATURE _____ DATE: ___/___/___

PATIENT ACCOUNT REGISTRATION **NAME**_____**D/O/B**_____