Cody Dental Group. *Established 1946*

Adult Registration – Confidential

Patient Last Name_____ First_____ MI____
Male____ Female____

Address_____City_____State/Zip_____

Home Phone_____Cell Phone_____E-Mail_____

Age_____Date of Birth_____ SS#_____
(optional)

Spouse (if married) _____

Name of Employer_____ Occupation_____
Employer's Address_____
Business phone #_____

Spouse's Employer_____Occupation_____
Employer's Address_____
Business phone #_____

Emergency Contact_____Phone Number_____
Relationship to Patient_____
I hereby allow CDG to discuss, with this emergency contact person, your treatment, health history, and financials. Yes_____ No_____

Billing Information

Dental Insurance: Yes_____. No_____. (If you have dental Insurance, please provide that information on the reverse side of this form. The following information must be completed regardless of insurance coverage.)

Responsible Party_____
Address_____City_____State/Zip_____
Home/Cell Phone_____ Work Phone_____

New patient visits require payment on the same day as treatment. Any services billed must be paid upon receipt of statement unless arrangements are made prior to treatment. Credit reports are obtained on all new patients to determine financial eligibility and down payment requirements. A monthly finance charge of 1.5% (18% annually) begins on charges 60 days after billing. Should the account be turned over to a collection agency, I agree to pay all costs of collection including, but not limited to, court costs, agency fees and attorney fees.

Has any member of your immediate family been treated here? _____
*If yes: Name*_____*Relationship*_____

How did you hear about us?? Website____ Mailer___ Signage____ Facebook____ Instagram____
Internet search___ Welcome Wagon____ Insur.website____Referred By:_____

FOR OFFICE USE ONLY. Date_____Doctor_____ Account#_____

Dental Insurance Information

PRIMARY CARRIER:
Name of Insurance Company_____

Address_____

City_____State/Zip_____

Name of Policy Holder_____Policy Holder DOB_____
Policy #/SS #_____Group #_____

Name of Employer_____
Address_____
City_____State_____Zip_____

SECONDARY CARRIER:
Name of Insurance Company_____

Address_____

City_____State/Zip_____

Name of Policy Holder_____Policy Holder DOB_____
Policy #/SS#_____ Group #_____

Name of Employer_____
Address_____
City_____State_____Zip_____

PLEASE NOTE: *We will provide a computer-generated insurance form following each visit and submit the insurance form to your insurance company. A Pretreatment estimate will be submitted to your insurance company* ***upon request only.* *Please check with your insurance company to determine pretreatment filing requirements. Patients are confused about how much the insurance company will pay. Percentages are reimbursed based on the insurance company's table of allowance – not the dentist's charges.*

You are responsible for the full payment of the services charges.

PLEASE ACKNOWLEDGE YOU HAVE READ THE ABOVE BY SIGNING BELOW:

Signature_____Date_____