JEFFERSON FAMILY SMILES

231 Espanong Road, Lake Hopatcong, NJ 07849
973-663-4444

PATIENT REGISTRATION

Patient Information

First Name: _____ Last Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____ Ext: _____
Date of Birth: _____ Social Security #: _____
E-mail: _____
Gender: _____ Select: ◊Minor ◊Single ◊Married ◊Divorced ◊Widowed ◊Separated
Referred By: _____
Last Dental Visit (Date) _____

Dental Insurance Information

Policyholder: _____ Relationship to Patient: _____
Address: _____
City, State, Zip: _____
Date of Birth: _____ Social Security #: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____ Ext: _____
Employer: _____
Address of Employer: _____
City, State, Zip: _____
Insurance Company: _____
Policy ID#: _____ Group #: _____

DO YOU HAVE ADDITIONAL DENTAL INSURANCE? YES NO - IF YES, COMPLETE THE FOLLOWING:

Policyholder: _____ Relationship to Patient: _____
Address: _____
City, State, Zip: _____
Date of Birth: _____ Social Security #: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____ Ext: _____
Employer: _____
Address of Employer: _____
City, State, Zip: _____
Insurance Company: _____
Policy ID#: _____ Group #: _____

CONSENT FOR TREATMENT

I agree to treatment of my (my dependent's) oral/dental health by the practitioners of Jefferson Family Smiles. Sign_____ Date _____

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FINANCIAL AGREEMENT

I acknowledge that any treatment rendered upon me or my dependent(s) incurs fees, which are my responsibility to cover. I agree to pay any payment due from me at the time of service, including insurance deductibles, copays, or any amount not covered by dental insurance. If I have dental insurance, I must provide this office with the correct information so that it can be processed in a timely manner. It is my responsibility to ascertain whether or not I am covered by dental insurance at the time of service. Balances incurred due to non-coverage are in no way the responsibility of this dental office. Any payment due from me must be paid in full at the time of service or within 30 days of receiving a statement. If full payment cannot be made, I will be directed to apply for a line of no-interest or low-interest funding through Care Credit. In some cases, a payment plan can be set up directly through this dental office, to satisfy the debt within 6 months. I should seek out these solutions before my debt becomes delinquent for more than 30 days. This dental office is under contract with a collection agency, which will take charge of collecting delinquent debts.

I hereby authorize and guarantee payment for all services rendered.

Although fees for services are due and payment expected at the time services are rendered, if I have been granted a grace period for payment of fees (i.e., my statement is sent out sometime later rather than immediately) I acknowledge that payment is due and expected at the time the billing statement is received.

In the event that my account becomes delinquent for more than 30 days, I also agree to pay a finance charge of 1.5% per month on any balance due, as well as all reasonable collection costs not to exceed 50%, court costs, attorney fees and interest fees accrued with the collection of this account.

Print Name: _____
Responsible Party

Signed: _____

_____
Date