SNOQUALMIE FALLS DENTAL

Advanced Family Dentistry on The Ridge

New Patient Registration

Patient's Name: _____ DOB: _____

Parent/Guardian's Name: _____ DOB: _____

Address, city, state, zip: _____

Home Phone:_____ Cell Phone:_____

Work Phone, if ok to contact you there: _____ Other contact if desired:_____

Email Address:_____ Preferred method of contact? _____

Please tell us how you heard or found out about our office? (If someone referred you, please include their name so that we may send them a thank you gift!) _____

Insurance Information

Subscriber's Name: _____ DOB: _____ Relationship to patient:_____

Subscriber's Employer: _____ Subscriber's ID#: _____

Subscriber's SS# _____ Insurance Carrier: _____ Group#: _____

Insurance Address & Phone #: _____

_____

Secondary Insurance Information (If applicable)

Subscriber's Name: _____ DOB: _____ Relationship to patient:_____

Subscriber's Employer: _____ Subscriber's ID#: _____

Subscriber's SS# _____ Insurance Carrier: _____ Group#: _____

Insurance Address & Phone #: _____

_____

Payment is due at the time services are rendered. As a courtesy, we will verify your benefits and submit claims on your behalf. Every effort will be made to provide you with an accurate estimate prior to any dental services being rendered. However, please remember that it is your responsibility to verify coverage is active before your appointment. Any monies due after your insurance payment is received will be due within 30 days. Any balances on the account longer than 30 days will be subject to a finance charge of 8%. If your account goes into collections, you will be responsible for filing, court, collection and attorney's fees. There is a returned check fee equal to the amount we are charged by the bank plus a $20.00 processing fee of our own. Services over $2,000 will require a deposit.

While we encrypt all of your patient data, electronic communications to you may at times happen through unencrypted pathways. Let us know if you are not ok with this and would prefer another method? Initials ___

I agree to and understand the terms of Snoqualmie Falls Dental's financial policy and insurance statement. I also acknowledge that a copy of Snoqualmie Falls Dental's Notice of Privacy Policy was made available to me to take if I so desired. All of the information that I have given is complete and accurate.

Signature (Initials for digital signature): _____ Name: _____ Date: _____

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