WEISHAAR WEBER

SUE WEISHAAR.DDS ANTHONY WEBER.DDS

PATIENT REGISTRATION

Patient first name: _____ Last name: _____ I prefer to be called _____

SS#: _____ DOB: _____ (please circle) Gender: M F

Address: _____ Mailing Address_____

City: _____ State: _____ Zip: _____ Home Phone:_____

Cell #: _____ E-Mail address:_____

Employer: _____ Occupation: _____ Work #: _____

(please circle) Confirm appts at: Home # Work # Cell # /Text E-Mail address

(please circle) Martial Status: Single Married Separated Divorced Widowed

Who may we thank for your referral ?_____

Emergency Contact: _____ Cell phone: _____ Home phone: _____

INSURANCE INFORMATION/ AUTHORIZATION AND RELEASE

Primary Insurance Carrier: _____Policy Holder:_____ Employer:_____
ID/SS# _____ Relationship: _____

Secondary Insurance Carrier:_____ Policy Holder: _____Employer:_____
ID/SS# _____ Relationship: _____

I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered to me or my dependents.

FINANCIAL ARRANGEMENTS

For your convenience, we offer the following methods of payment
Cash - Personal Check- Debit Card - Credit Card (Visa, Mastercard, Discover)-Care Credit (outside financing option)

I realize that failure to keep this account current may result in being unable to provide additional dental services except for dental emergencies or where there is **prepayment** for additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances. A $25 NSF fee will be applied for any returned check.

Signature: _____ Today's Date: _____

Nov 2003

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