ROCKY RIDGE DENTAL ASSOCIATES, LLC

PATIENT REGISTRATION INFORMATION

Welcome to our office. We will do our best to make your appointments as convenient and as pleasant as possible. If at any time you have questions regarding your treatment, your appointments, or our fees, please feel free to ask.

Please tell us whom we make thank for referring you to our office: _____

Patient's Name: _____
First *MI* *Last* *Prefer*

Home Address: _____ Phone: _____
Street *City* *State* *Zip*

E-Mail Address: _____ Date of Birth: _____ Married: _____ Single: _____

Person Responsible for Account: _____ Date of Birth: _____

Address: _____

Relationship to Patient: _____ Home Telephone: _____ Business: _____

IF YOU HAVE DENTAL INSURANCE, PLEASE COMPLETE THE FOLLOWING

PRIMARY INSURANCE COVERAGE

Insurance Company: _____Telephone: _____

Address: _____

City: _____ State: _____ Zip: _____

Group Plan: (Company Name) _____ Group Number: _____

Policy Holder's Name: _____ Contract Number: _____ Date of Birth: _____

SECONDARY INSURANCE COVERAGE

Insurance Company: _____Telephone: _____

Address: _____

City: _____ State: _____ Zip: _____

Group Plan: (Company Name) _____ Group Number: _____

Policy Holder's Name: _____Contract Number: _____ Date of Birth: _____

POLICY ON MISSED APPOINTMENTS

Our office makes every effort to schedule your appointment at a time convenient for you to complete your dental treatment. We do not "double book" to compensate for patients who miss their appointment. In an effort to keep our office overhead expenses controlled, we will charge $50 per hour for any appointment missed without a 24 hour cancellation notice.

I, _____ understand the missed appointment policy.

FEES FOR TREATMENT RECEIVED ARE PAYABLE BY CASH, CHECK, AMERICAN EXPRESS, DISCOVER, MASTERCARD, OR VISA AT THE COMPLETION OF EACH APPOINTMENT. OTHER ARRANGEMENTS FOR PAYMENT MUST BE MADE PRIOR TO TREATMENT.

FINANCE CHARGES : THERE IS A 1.5 % PER MONTH FINANCE CHARGE ON THE UNPAID BALANCE OVER 30 DAYS OLD.

I (we) the undersigned hereby agree to pay all amounts and charges hereafter incurred by myself and members of my family for services received. Failure to make payment when requested is basis for legal action and the undersigned agrees to pay all costs of collections including a reasonable attorney fee and hereby waive their rights of exemption under the law of the state of Alabama and any other state.

Date _____ Signature _____

INFORMATION FOR OUR PATIENTS WITH DENTAL INSURANCE

Our office is happy to cooperate with our patients who are covered by dental insurance. Our experience with dental insurance is extensive, and we are prepared to assist you in obtaining the maximum benefits available from your insurance. We will accept assignment of your insurance benefits after you provide us with the following:

1. A copy of your insurance coverage.
2. Appropriate insurance forms with your portion completely filled out and signed.
3. Payment, at the time of service, of your out-of-pocket expenses (usually a deductible and/or percentage of the total).

Due to increasing complications in filing and coordinating benefits for multiple insurance coverage, our office will only accept primary and secondary coverage. Patients with more than two carriers must file for benefits beyond their secondary carrier.

You should understand that our professional services are rendered to you, our patient, not to your insurance company. You are personally responsible for your account.

Alabama law requires Alabama-based insurance companies to satisfy a claim within 45 days. This office files insurance claims the day service is rendered. If your insurance company does not settle your account within 60 days, you should be prepared to do so. The fees we charge for services rendered to those who are insured are our usual and customary fees charged to all patients for similar services. Please feel free to discuss any facet of your dental insurance coverage with us.

I, _____, understand the insurance policy.
(Please sign)