Maize and Blue Dental, P.C.
2792 Packard Rd.
Ypsilanti, MI 48197

PATIENT REGISTRATION FORM

Date _____

Patient Name	Soc Security #	Birthdate
Spouse/Parent Name (if patient is Dependent)	Soc Security #	Birthdate
Other Parent Name (if patient is Dependent)	Soc Security #	Birthdate
Street Address	**City, State, Zip**	**Home Phone #**
E-mail Address	**Work Phone #**	**Cell Phone #** *(Required)*

Patient/Parent Employer	Work/Employer Phone #	Business Address
Spouse Employed by:	Work/Employer Phone #	Business Address
In Case of Emergency, Call:	Phone #	Relation:

Name of Dental Insurance	Name of Person Insurance is Under
If Covered by 2nd Dental Insurance, Name	Name of Person Insurance is Under

How did you hear about us/
Who recommended our office?
 Google Facebook Internet search/Ad Yellow Pages
 Insurance Listing Family Member Friend _____
Family or Friend
name

**** Gift Cards Preference ($10 given for each referral to our office):** Meijer Target Starbucks Subway Panera

FINANCIAL OBLIGATIONS AND CONSENT

1. I hereby authorize Maize and Blue Dental or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate to make a thorough diagnosis of my dental needs.

2. Upon such diagnosis, I authorize Maize and Blue Dental to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I understand that even after a complete examination and treatment is planned and discussed, my treatment needs may change, resulting in a change in the costs.

3. I consent to the use of appropriate medication and therapy as deemed necessary to properly administer dental treatment. I fully understand that using anesthetic agents embodies certain associated risks.

4. I authorize release of any information relating to my insurance claims. I also authorize payment of such claims directly to Maize and Blue Dental and waive any insurance benefits otherwise payable directly to me. I understand that all co-pay estimation are not guarantees, but an estimate of what my insurance will not cover. I understand that filing of insurance claims is a courtesy Maize and Blue Dental extends to patients and acknowledge that all charges, covered or uncovered by insurance, are my responsibility. I agree to be responsible for payment of any services rendered to me or my dependents.

5. I understand that payment is due at the time of service unless other arrangements have been made in advance. In the event payments are not received by agreed upon dates service charges and/or interest may be added to my account. I understand that any unpaid balance on my account of 30 days or more will be assessed a finance charge of 1.5% per month (18% per year). Returned checks shall be subject to a $35.00 fee. I understand that if treatment or a service has not been fully paid for, I may not be able to schedule additional appointments in the future.

6. I understand that in the event any unpaid balance is placed for collections with any third party collection agency, a fee of 33% of the unpaid balance will be added to the total amount due. This amount shall be in addition to any other costs incurred to collect amounts owed under this agreement such as court costs, attorney fees, and all other expenses so stated elsewhere.

7. I understand that if I do not show up for a scheduled appointment, or if I have cancelled an appointment with less than 48 hours notice, that I will be assessed a fee of $75 and/or may be required to leave a deposit to reserve future appointments.

Patient, Parent, or Responsible Party Signature _____ **Date** _____