Patient Registration

Patient: First Name_____ Last Name_____

Address:_____ City:_____ State:_____ Zip:_____

DOB:_____ SS#:_____ Driver License#:_____

Home Phone #:_____ Mobile #:_____ Work #:_____

Marital Status: _____

Responsible Party (if different than patient) Name:_____

Address:_____ City:_____ State:_____ Zip:_____

DOB:_____ SS#:_____ Driver License#:_____

Insurance Subscriber (if different than patient) Name:_____

Address:_____ City:_____ State:_____ Zip:_____

DOB:_____ SS#:_____ Driver License#:_____

Financial Policy

Dr. Sierra and his staff are committed to working with our patients to make dental care affordable. For your convenience our office accepts Discover, Master Card, Visa, Personal Checks and of course Cash and Debit Cards. We also offer financing options through Care Credit and Lending Club. Payment is due at the time services are rendered unless other arrangements have been made in advance. **Please Initial**_____

Patients with no dental coverage are expected to pay in full on the date treatment is rendered. If this is not possible, please discuss with our front desk team member **before** treatment begins. In most situations we can schedule appointments to accommodate you financially. **Please Initial**_____

We accept indemnity insurances which are plans that allow patients to go to a Dentist of their choice. We are not In-Network or Contracted with any insurance company. Patients with insurance are responsible for payment of unmet yearly deductibles and percentages not covered by their insurance plan. Our office does make every effort to obtain accurate insurance benefit information. However, this is not always possible. Ultimately you are responsible for any balance your insurance does not cover. **Please Initial**_____

Consultations can be arranged to discuss your insurance benefits and to submit a pre-determination to your insurance company to clarify coverage. Some of the procedures we perform may not be covered under your specific plan. Most insurance companies have frequency limitations regarding some procedures.

Your questions are welcomed regarding our Financial Policy. We will be glad to discuss them with you. We strive to provide the highest quality of care at an affordable price regardless of your financial situation.

ACKLOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTIVE

HIPPA: I have received and/or reviewed a copy of our dental practice's privacy policies and procedures.

Print Name:_____

Signature:_____ **Date:**_____