STAN D. TURNER D.D.S., P.C. GARRETT TURNER D.D.S.

Patient Registration Form

Name: ______________________________ **Date of Birth** _____/_____/_____
First MI Last Month Day Year

Social Security #________/_____/______ ( ) M ( ) F **Preferred Pharmacy**______________________

Address______________________________ **Phone** ___________/____________/___________
Number & Street City State Zip Home Work Cell

Email Address____

Parent or/ Legal Guardian____
(Of minor child)

How did you hear about us? ____

Physician____
Name Address Phone #

DL#:_________________________________ **Phone # to verify appts:**_________________________________

Insurance Co.____
Name Address Phone #

Policy Holder____
Name Address Date of Birth

SS# or Policy #:_______________________________ **Employer**_________________________________
Name & Address

Please present insurance card or photo ID to the receptionist so copies can be made.

In order to establish optimal relations with our patients and avoid misunderstandings regarding our payment policies, our staff is trained to inform you of the financial policies of this office. **Payment is required at the time of treatment**. For those patients, applicable co-payments and deductibles will be collected. We accept payment in the form of cash, check or credit card. Should a check be returned as insufficient funds, there is a $30.00 service fee. In the event of a major treatment plan, our office may file a pre-determination. Upon receipt of this form from your insurance carrier, you will be required to pay any co-payments, and or deductibles before procedures are performed. In the event that your account must be turned over to collections the collection fee will be added to your account. Your signature below signifies your understanding and willingness to comply with this policy. Further, your signature authorizes the office of Stanley D. Turner D.D.S., P.C. to release such dental information necessary to process insurance claims (if any). You herein authorize payment of dental benefits to the office of Stanley D. Turner D.D.S., P.C. when an assigned claim is filed. You also authorize the release of dental information to referring dentist if needed for consultation and or treatment.

____ **Date:** _____/_____/_____
Signature-Patient, Parent, or Legal Guardian Month Day Year

Do we have permission to?
Leave a message on your home answering machine? (_) yes ( ) no
Leave a message at your place of employment? ( ) yes ( ) no
Authorization to fax or verbally verify appointment with your child's school or your place of employment? ( ) yes ( ) no
Discuss your dental condition with any other family member? ( ) yes ( ) no

If yes, whom? ______________________________________**Relationship**__________________________

____ **Date:** _____/_____/_____
Signature-Patient, parent, or legal guardian signature Month Day Year