PATIENT REGISTRATION

Please circle the options that apply to you

Patient First/ Last Name:____

Preferred Name: _________________________________ DOB:_____________________

GENDER: MALE // FEMALE Phone Number:____________________________

How did you hear about our office? ____

Alternate phone number (If available): ________________**Social Security #:** _______________

Marital Status: SINGLE // MARRIED // DIVORCED // SEPARATED

Spouse/significant other/partner's Name: ____

Phone Number: ____

EMERGENCY CONTACT INFO

***IN AN EVENT OF AN EMERGENCY, OTHER THAN YOUR SPOUSE, WHO CAN WE CONTACT?**

- **First/last name:** ____
- Relationship to you? ___________________**Phone #:** ___________________________
- **Email (If available):** ____

DENTAL INSURANCE INFO

***If we already have your dental insurance on file, you can skip this step**

PRIMARY Dental Insurance Name: ____
Customer Service #: _______________________**Member ID#:** ______________________
Subscriber Name: ________________________ **Subscriber DOB:** __________________

SECONDARY Dental Insurance Name: ____
Customer Service #: _______________________**Member ID#:** ______________________
Subscriber Name: ________________________ **Subscriber DOB:** __________________

PATIENT REGISTRATION

NOTICE OF PRIVACY PRACTICES

Dr. Pawandeep Kaur, DDS –Renton Smile Dentistry

Most of us feel that our health information is private and should be protected. That is why there is a federal law that sets rules for health care providers and health insurance companies about who can look at and receive our health information. This law, called the **Health Insurance Portability and Accountability Act of 1996 (HIPAA),** gives you rights over your health information, including the right to get a copy of your information, make sure it is correct, and know who has seen it.

Our office is dedicated to protect the privacy rights of our patients and the confidential information entrusted to us. The commitment of each employee to ensure that your health information is never compromised is a principal concept of our practice. We may, from time to time, amend our privacy policies and practices but we will always inform you of any changes that might affect your rights.

***COPY OF NOTICE AVAILABLE UPON REQUEST ***

I HEREBY AKNOWLEDGE THAT A COPY OF RENTON SMILE DENTISTRY'S NOTICE OF PRIVACY PRACTICES HAS BEEN MADE AVAILABLE TO ME. I HAVE BEEN GIVEN THE OPPORTUNITY TO ASK ANY QUESTIONS I HAVE REGARDING THIS NOTICE.

X____ **X**______________________

Patient Signature Date

X____ **X**______________________

(If you are minor) Parent or Guardian Signature Date

PATIENT REGISTRATION

Financial, Insurance & Appointment Policy

Please read thoroughly and initial each line, this indicates that you understand the statement

_______________ If you do not have a dental plan, please be prepared to fully pay the fees for each of your visits. If you are interested in our in house dental plan, please inquire with administrative staff at check in.

_______________ I understand that my dental insurance policy is a contract between the insurance company and myself. I also understand that Renton Smile Dentistry is NOT a party and/or associated with my insurance agreement/policy.

_______________ As a service to our patients, we will bill your insurance if you have provided us with your insurance card/information and we have been able to verify your benefits. It is your responsibility to keep us updated on any changes of insurance. If you fail to do so, it will be your responsibility to clear the outstanding balance.

_______________ Dental benefits policies vary; many have exclusions and limitations, and services provided in this office may not be covered. We are available to answer your questions and help you maximize the benefits available to you. I authorize the release of all medical/dental care information necessary to process my claim. I hereby authorize payment to **Dr. Pawandeep Kaur, DDS** of the benefits otherwise payable to me.

_______________ Renton Smile Dentistry will provide you with an estimate for treatment; however **we make no guarantee of estimated coverage.** Estimates are **never a guarantee of payment,** if insurance denies payment; you are legally responsible for the balance on your account. You are responsible for all collection costs, attorney fees, and court costs. **Failure of payment may result in account being forwarded to collections.** . I understand that my account becomes delinquent if not paid within sixty (60) days after billing and that at that time a finance charge of 1.0% of the unpaid balance will be charged every month until the balance is paid in full (RCW 19.52.020).

_______________ I hereby give my consent to Renton Smile Dentistry, the office of Dr. Pawandeep Kaur, DDS to provide dental treatment as deemed necessary.

_______________ Upon scheduling any appointments outside of routine dental cleanings/annual exams, we will require co-insurance payment and/or a deposit to hold appointment date/time- unless otherwise discussed

_______________ I understand the appointment policy listed below and have asked all appropriate questions necessary to clarify this policy.

- ***Your appointment date/time is reserved specifically for you and the doctor and/or the hygienist.***
- We do require a ***2 day notice*** for any cancellations and/or reschedules-***otherwise a $75 fee per hour*** **will be applied to your account.**
- **Due to limited availability for Saturday appointments, we require a 3 day notice**
- Any voicemails and /or texts sent to our office regarding adjustments- need to abide by these guidelines in order to avoid penalty

PATIENT REGISTRATION

***I understand that Renton Smile Dentistry accepts the following forms of payment:**

- ✓ **VISA // MASTERCARD // AMEX // DISCOVER // CASH/CHECK // HSA // FSA**
- ✓ **CARE CREDIT //** ***In house financing- to be discussed on case-case basis; depending on treatment***

I certify that I have read and I understand the questions/statements and financial policy. I acknowledge that my questions if any, regarding the inquires set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of her staff, responsible for any errors or omissions that I have made in completion of this form.

X____ **X**____________________

Patient Signature Date

X____ **X**____________________

(If you are minor) Parent or Guardian Signature Date