Kirt Kirchmeier, DMD

PATIENT REGISTRATION

Date:_____

Name:_____ Date of Birth:_____ Sex:_____

Address:_____Apt #: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Work:_____

Email: _____

Social Security No. _____

Drivers License No._____

We offer electronic appointment reminder options for our patients via text and email messaging. Please indicate if you would like to receive messaging via these options:
TEXT Yes or No **EMAIL** Yes or No

Employer/occupation: _____ Work Phone: _____

Student Status: F/T or P/T Name of School:_____City/State_____

Emergency Contact Name:_____ Phone: _____

How did you hear about our office? _____

Insurance Information

Please provide insurance card

Primary Dental Insurance: _____ Employer:_____

Subscriber:_____DOB:_____ Group # _____ ID #_____

Secondary Dental Insurance: _____ Employer:_____

Subscriber:_____DOB:_____ Group # _____ ID #_____

Responsible Party (if other than patient) Name: _____

Address: _____ City: _____State: ____ Zip_____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Relationship to patient: _____

~ Turn Over ~

Consent for Treatment

Consent I, the undersigned, hereby authorize the doctor to take radiographs, study models, photographs or any other diagnostic aids he/she deems appropriate to make a thorough diagnosis of my dental needs. I also authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I authorize and consent that the doctor employ any such assistance as he deems appropriate.

I further authorize the release of any information, including the diagnosis, radiographs and records of any treatments or examinations rendered to my insurance company, consulting professionals or others who may request my records. I understand that I am personally responsible for payment of all fees for dental services provided in this office for me or my dependents, regardless of insurance coverage. Breach of this responsibility carries the penalty of compensating the practice for any related attorney's and collection fees. I understand that payment is due when services are rendered. Any other arrangements for payment must be made before treatment begins. Initial_____

Dental Insurance

Dental insurance is a contract between your employer and the dental insurance company. The benefits that you will receive are based on the terms of the contract that were negotiated between your employer and the dental insurance company and not your dental office. It is the responsibility of the insured to become familiar with the coverage benefits, limitations and exclusions of their dental plan. We realize the complexity of dental benefits and eligibility and are here to assist you in making the most of your insurance without compromising quality dental care. We will prepare and bill your insurance claims as a courtesy to you and provide clinical information and radiographs as needed.

I understand that any agreement for dental coverage is between my insurance company and me. I understand that estimated portions due at the time of service are based on estimates of expected coverage, which may not be disclosed nor guaranteed by my insurance company. I understand that my portion may be more if my insurance company does not pay the anticipated amount. I also understand that services are rendered independent of insurance reimbursement. I further understand that it is my responsibility to provide current insurance information for dental procedures to be billed on my behalf or notify the dental office of coverage termination. Initial_____

Appointment Scheduling and Cancellation Policy

An appointment in our schedule is a bond of trust that we will be here to serve you and you will be present for treatment. We strive to create a schedule that most efficiently provides for the dental needs of all of the patients we serve. We respectfully request 48 hours notice to reschedule or cancel an appointment. This allows us time to move patients on the waiting list in to earlier appointment days and times. A late cancellation or no-show for an appointment may be subject to a cancellation fee of $60.00. We understand that emergencies do come up and certainly are willing to work with you to find an appointment time that works best in your schedule.

Initial_____

I understand and consent to the dental treatment and associated financial responsibility for dental work performed by Dr. Kirt Kirchmeier, DMD, his hygienist and staff: I agree to pay all treatment costs either directly or in concert with my dental insurance. I agree to pay finance charges, collection costs, attorney's fees, and any other costs incurred to enforce the collection of any outstanding amount.

My signature below indicates I understand and agree to all the above.

_____ _____

Signature (or Guardian if a minor) Date