REGISTRATION FORM

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name: First: Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:

Street address:	Social Security no.:	Home Phone No.: ( )

P.O. box:	City:	State:	ZIP Code:

Employer Phone No.: ( )	Employer:	Cell Phone No: ( )

Chose office because/Referred to office by (please check one box):	❑ Dr.	❑ Insurance Plan	❑ Hospital

❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Other

Other family members seen here:	Email Address:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance:				

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Horizon One Dental or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

Horizon one DENTAL

Beautiful Smiles, Exceptional Dentistry

Authorization to Discuss Dental Treatment and Account History

I _____ authorize that the following people have my permission to discuss my dental treatment and account history with Horizon One Dental.

_____	_____	_____
Name	Relationship to Patient	Phone
_____	_____	_____
Name	Relationship to Patient	Phone

_____

Patient Signature

_____

Date

8004 Summerlin Lakes Drive ~ Fort Myers, FL 33907 ~ 239-267-7385 ~ Fax 239-267-7273 ~ info@horizonondental.com

Financial Policy

Payments for services are due at the time services are rendered unless payment arrangements have been approved in advance.

Payment Options:

- Cash, Check, Visa, MasterCard, Discover, American Express
- Payment plans available
- Convenient Monthly Payment Options from CareCredit Healthcare Credit Card
  - Flexible financing options
  - 0% interest finance options
  - Allow you to pay over time
  - No annual fee or pre-payment penalties

Insurance:

Horizon One Dental will be happy to help you process your insurance claim for reimbursement. You must realize, however, that:

1. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.

2. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

3. If your dental insurance has changed we request that you give Horizon One Dental 24 hours notice prior to your dental appointment to allow adequate time for proper verification of insurance.

Horizon One Dental must emphasize that as dental care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered.

Return Checks:

Horizon One Dental charges $25 for returned checks.

*****Please note that Horizon One Dental also reserves the right to charge for any missed or canceled appointments without a 24 hour advance notice. The fee for missed or canceled appointments is $ 50.00.*****

_____	_____	_____
Patient Name	Patient Signature	Date

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