



New Patient Registration

Patient's Name: _____ DOB: _____

Parent/Guardian's Name: _____ DOB: _____

Address: _____

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

Email Address: _____ Employer: _____

If you would like your appointment reminders sent via text message, please include your carrier here: _____
Which is your preferred method of contact? _____

How did you hear or find out about our office? _____

Insurance Information

Subscriber's Name: _____ DOB: _____ Relationship to patient: _____

Subscriber's Employer: _____ Subscriber's ID#: _____

Subscriber's SS# _____ Insurance Carrier: _____ Group#: _____

Insurance Address & Phone #: _____

Secondary Insurance Information (If applicable)

Subscriber's Name: _____ DOB: _____ Relationship to patient: _____

Subscriber's Employer: _____ Subscriber's ID#: _____

Subscriber's SS# _____ Insurance Carrier: _____ Group#: _____

Insurance Address & Phone #: _____

Financial policy & Insurance statement

Payment is due at the time services are rendered. As a courtesy, we will verify your benefits and submit claims on your behalf. Every effort will be made to provide you with an accurate estimate prior to any dental services being rendered. Any monies due after your insurance payment is received will be due within 30 days. Any balances on the account longer than 30 days will be subject to a finance charge of 8%. If your account goes into collections, you will be responsible for filing, court, collection and attorney's fees. There is a returned check fee equal to the amount we are charged by the bank plus a \$15.00 processing fee of our own.

I agree to and understand the terms of Snoqualmie Falls Dental's financial policy and insurance statement. I also acknowledge that a copy of Snoqualmie Falls Dental's Notice of Privacy Policy was made available to me to take if I so desired. All of the information that I have given is complete and accurate.

Initials for digital signature: _____ Name: _____ Date: _____