Westdale Dental
Patient Registration Form

Today's Date _____

Marital Status
☐ Single ☐ Divorce
☐ Married ☐ Separated
☐ Widowed

Patient Name _____ _____ Preferred Name _____
First Last

Social Security Number _____ Birth Date _____ Home Phone _____

Cell Phone _____ Email Address _____

Residence Address _____ City _____ State _____ Zip _____

Employed by (Name & Address) _____ Business Phone _____

Spouse Name _____ Spouse Birth Date _____ Spouse SS# _____

Cell Phone _____ Email Address _____

Spouse Employed by (Name & Address) _____ Business Phone _____

How did you hear about our office? ☐ Website ☐ Phonebook ☐ Friend or family (name)_____
☐ Insurance company ☐ Drive by ☐ other _____

Primary Dental Insurance_____ Name of Policy Holder _____Policy Number_____

Secondary Dental Insurance_____ Name of Policy Holder _____Policy Number _____

We would like to stress the importance of arriving at all scheduled visits. The appointments you make with your Doctor are for your own personal convenience and with concern for you, the patient. Our scheduling is a very important part of our office. Please notify us 24 hours in advance of any problems you may have in keeping your dental appointments. 3 missed appointments will require us not to be able to reappoint you.

Payment is requested at the time of service, please choose one of the following

_____ Payment in full with cash or check - you will receive a 10% discount

_____ Payment by Mastercard, Visa or Discover Cards

If you have Dental Insurance, we will gladly process your claim, but we request that you pay your estimated portion when services are rendered.

Please choose one of the following for payment of your copayment/deductible

_____ Payment with cash or check

_____ Payment by Mastercard, Visa or Discover cards

To avoid disappointment, we strongly suggest that patients contact their insurance company to make certain their dental insurance assumptions are correct. As you know, most insurance companies pay only a portion of the dental investment.

Further, patients must realize that professional services are rendered to a person, not to an insurance company. Hence, the insurance company is responsible to the patient and the patient is responsible to us. We cannot render services on the assumption that the charges will be paid by an insurance company. However, we will help in any way we can.

Occasionally, legitimate situations arise that may prevent one from making payments to this office on schedule as prearranged. To avoid misunderstandings, we should be notified so that we may make the necessary adjustment on your account, and an 18% interest per annum will be charged for any balance 90 days or over.

I understand that credit bureau reports may be obtained in case financing of treatment may be requested.

Date_____ Signature of Patient_____