PATIENT REGISTRATION

Date____________

Patient's Name____________________ Birth Date____________ Sex____________

Person Responsible ____________________ Birth Date____________ SS No.____________

Address: Mailing____________________ Phone____________

Residence____________________ Own_____ Rent_____

Employer____________________ Address ____________________

Position ____________________ Work Ph.____________ How Long________

Spouse____________________ Birth Date____________ SS No.____________

Spouse's Employer ____________________ Address ____________________

Position ____________________ Work Ph.____________ How Long________

Nearest Relative____________________ Address____________________ Phone ____________

Whom may we thank for referring you to our office ____________________

DENTAL INSURANCE INFORMATION

Insurance Company ____________________ Address ____________________

Group No.____________________

Second Coverage____________________ Address ____________________

Group No.____________________ Patient's Relationship to Insured____________________

I give Laurence E. Putman, DDS PC, permission to mail my Social Security # on my family's Insurance Claims. _____

Insurance claim forms will be filled out without additional charge. However, patients must realize that services are rendered to a person, not an insurance company. We will assist you in any way possible.

PAYMENT POLICY

Treatment is provided for you with payment expected on the date of treatment. If you are requesting us to carry your account, the following conditions apply.

1. **All** balances will be billed monthly upon approval of credit.
2. Specific payments apply. Please make arrangements before you leave.
3. **Insurance accounts:** Monthly payments are required starting with your first statement.
4. Monthly payments are due by the 20th of the month following billing.
5. You will be responsible for all collection costs and attorney fees.
6. **A monthly finance charge will be assessed after 60 days on account.**

CREDIT REFERENCES

1. Bank____________________ Checking_____ Savings_____ Loan_____

   Checking Account No.____________________

2. Credit Cards 1.____________________ 2.____________________ 3.____________________
3. Finance Company ____________________
4. Other____________________

I UNDERSTAND I AM FINANCIALLY RESPONSIBLE TO SAID DOCTOR FOR CHARGES FOR ALL SERVICES RENDERED. I HEREBY AUTHORIZE THE ABOVE DOCTOR TO FURNISH THE INSURED'S INSURANCE COMPANY ALL INFORMATION WHICH SAID INSURANCE COMPANY MAY REQUEST CONCERNING MY PRESENT CLAIM. I HEREBY ASSIGN TO THE DOCTOR ALL MONEY TO WHICH I AM ENTITLED FOR EXPENSE RELATIVE TO THE SERVICES PERFORMED FROM TIME TO TIME, BUT NOT TO EXCEED MY INDEBTEDNESS TO SAID DOCTOR.

Responsible Party's Signature____________________ Date____________