PATIENT REGISTRATION FORM

Name: First_____ MI_____ Last_____ Nickname_____

Sex: M/F **Race:** _____**Date of Birth**: Month _____ Day _____ Year _____ **SSN/ID#:**___

Address: Street _____Apt:_____ City _____State ____ Zip _____

Phone Numbers: Home _____ Mobile _____ Work _____

Email address: _____ **Primary Medical Doctor:** _____

Emergency Contact: _____ **Emergency Contact Phone Number:** _____

General Dentist: _____ **Other Dental Specialist:** _____

Pharmacy: _____ **Pharmacy Location:** _____

Dr. Semmel has opted out of the Medicare program. Medicare will not pay for any medical procedures performed by Dr. Semmel. Therefore, Medicare will NOT ACCEPT any claims from Dr. Semmel or patient. If you have questions, please ask the staff.

Financial Policy: The following financial arrangements are available: (Please check one)

___**Option A: ALL PAYMENTS ARE DUE IN FULL AT TIME OF SERVICE**

* Cash, personal check, Visa, MasterCard, Discover, American Express or Debit Card accepted.

___**Option B: THIRD PARTY FINANCING**

*Patients wishing to finance treatment fees may be eligible for commercial financing. **Care Credit** is offered and can be applied for at www.carecredit.com. We participate in 6, 12, and 18 months, no interest options. They also offer longer term financing 24, 36, 48, & 60 month periods with reduced APR and fixed monthly payments.

Cancellation Policy: Please call the office within 48 hours of appointment if you wish to cancel your appointment. There will be a 75.00 fee if a 48 hour notice isn't provided.

_____ _____ _____

Patient (Guardian) Signature **Relationship to patient** **Date**

On your behalf, our office will file all NON MEDICARE claims. Please remember you are fully responsible for all fees charged by this office regardless of your insurance coverage.

Insurance Information & Parent/Guardian Information

Name: First_____ MI_____ Last_____ SSN: _____

Relationship to patient: (please check one): ( )Self ( )Parent ( )Guardian ( )Spouse ( ) Other _____

Address: Street _____ City _____State ____ Zip _____

Phone Number: _____ **Date of Birth**: Month _____ Day _____ Year _____

Employer of Insured Individual: _____ Group Number_____

Insurance Company Name: _____Secondary Insurance _____