<KENT K. MORIKADO, DDS, PC>
Patient Registration Form

Today's Date: ____/____/____

Patient Name: _____
(Last) (First) (Middle Initial) (Preferred Name)

Date of Birth: _____ Age _____

Home Address: _____ State/Zip: _____

Contact Number: (____) _____ ☐ Mobile Phone ☐ Home Landline

Email: _____

Referred By _____

Employer's Name and Address: _____

_____ Work Phone (____) _____

Person Responsible for Account, if different from the patient:

Name: _____ Relationship to Patient: _____

Date of Birth: ____/____/____

Home Address: _____ State/Zip: _____

Employer's Name and Address: _____

_____ Work Phone (____) _____

Emergency Information: name, address, telephone of a relative not living with you:

_____

Office Policy:

Initials

1. I authorize Doctor and staff to take necessary x-rays, study models, photographs and other diagnostic aids deemed appropriate to make a thorough diagnosis. _____

2. Our dental treatment is performed by scheduled appointment times. The Doctor and staff reserve a block of time that is set aside specifically for your treatment. Because this time is reserved only for you, and we will most likely not be able to fill the vacancy from a broken or short notice cancellation, we will charge a cancellation fee of $75 if the appointment is cancelled with less than 24 hours notice. _____

(over)

DENTAL INSURANCE INFORMATION

Insurance Company：	Group No.:
Customer Service Tel：	Member ID：
Employer：	Member Name：
	Member Date of Birth：

Do You Have Insurance?

- As a courtesy to you, we will help you process all your insurance claims. Please understand that we will provide an insurance estimate to you; however it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits ultimately determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible.
- All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company.
- Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.
- We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to assign benefits directly to our office.
- We ask that you pay the deductible and co-payment, which is the estimated amount not covered by your insurance company, by cash, check, MasterCard, Visa or Discover at the time we provide the service to you.
- We will file your claim promptly, and insurance payments are ordinarily received within 30-60 days from the time of filing. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure your claim is processed, and payment made for your benefit. If payment is not received or your claim is denied, you will be responsible for paying the full amount.
- We will fully cooperate with regulations and requests of your insurance company, so that claims are paid promptly. We thank you for the opportunity to serve your dental health care needs and welcome any questions you may have concerning your care or our financial policy.

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS.

* * * * *

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I authorize Doctor and staff to release to other health care providers or health care service plans, insurance companies, self-insurers, or their representatives any and all information and records (including x-rays) about my medical history, or about services rendered or treatment given to me, that is needed to review, investigate or evaluate any claims for benefits. If my coverage is under a group master agreement held by my employer, an association, trust fund, union or similar entity, this authorization also permits disclosure to them for purposes of utilization review or financial audit. I know that I have a right to receive a copy of this authorization if requested. Regarding my treatment, appointments, treatment fees, I authorize Dr. Morikado and his staff to discuss with:

FINANCIAL POLICY

Thank you for choosing our office as your dental health care provider. We are committed to providing you with the highest quality lifetime dental care, so that you may fully attain optimum oral health. Payment is due at the time service is provided. Our office accepts cash, personal checks, MasterCard, Visa, and Discover. CareCredit financing is available upon request and approval.

CONSENT:

I hereby authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that the responsibility for payment of Dental Services provided in this office for myself or my dependants is mine. I further understand that a finance charge or any fees associated with collection of an overdue account will be added to any overdue balance. I hereby authorize this office to obtain a copy of my credit report from a credit reporting agency for the purpose of considering payment options.

Patient Signature_____ Date_____/_____/_____

(Parent or Guardian of Child)