

Patient Name

Last	First	Initial

Soc. Sec. #

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Birthdate

Month	Day	Year

Susan K. Evans DDS, PA

New Patient Registration

If Child, Parent's Name: _____

How do you wish to be addressed: _____

Check one:

 Single
 Married
 Separated
 Divorced
 Widowed
 Minor

Residence (Street address): _____

City/State/Zip: _____

Business Address: _____

Telephone: Res. _____ Bus. _____

Fax: _____ Cell Phone # _____

email: _____

Patient/Parent Employed By: _____

Present Position: _____

How Long Held: _____

Spouse/Parent Name: _____

Spouse Employed By: _____

Present Position: _____

How Long Held: _____

Who is Responsible for this account: _____

Drivers License No.: _____

Method of Payment:
 Insurance
 Cash
 Credit Card

Other Family Members in this Practice: _____

Whom may we thank for this referral: _____

Patient/parent Social Security No.: _____

Spouse/Parent Social Security No.: _____

Someone to notify in case of emergency not living with you: _____

Relationship: _____ Phone #: _____

Address: _____

Consent

The undersigned hereby authorizes the doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs. I also 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.

PATIENT Signature (Parent of Child) _____

Date _____

DENTIST Signature _____

Dental Insurance: First Coverage

Employee Name _____ Date of Birth _____

Employer Name _____ Yrs. _____

Name of Insurance Co. _____

Address _____

Telephone _____

Program or policy # _____

Social Security No. _____

Union Local or Group _____

Dental Insurance: Second Coverage

Employee Name _____ Date of Birth _____

Employer Name _____ Yrs. _____

Name of Insurance Co. _____

Address _____

Telephone _____

Program or policy # _____

Social Security No. _____

Union Local or Group _____

Financial Arrangements

We offer the following payment options:

- We are a fee for service office.
- We gladly accept insurance assignments for patients with dental insurance, but require payment for the deductible and non-covered fees to be paid at each visit.
- I understand that my insurance is an agreement between my insurance company and myself. I also understand that I am responsible for the balance of my dental account regardless of my insurance. I further understand that a late charge will be added to any overdue balance.
- I assign dental payments to be paid directly to Dr. Evans from my insurance carrier.
- Payment in full by cash or check.
- Bank charge card -- Visa, Mastercard and Discover are accepted.
- Monthly payment plan: Financing is available through Hutchinson Credit Union and Dental Fee Plan. We will be glad to assist you in filling out an application (subject to credit approval). Small monthly payments (E.G. \$1,500 = \$51.00 per month/36 months).
- Major services: Appliances, crowns and bridges. Payments of 1/2 at the initial appointment and 1/2 upon completion. Partials and dentures must be paid for in full before they can be sent for processing.

REGISTRATION

Cut immediately ABOVE this line