G² Dental
family dentistry

Patient Registration

Date: _____

Patient Name:

_____
(Last) (First) (Mi)

Birthdate: _____

Home Address: _____
(Street) (City) (State) (Zip)

Telephone: Home: _____ Business: _____ Cell: _____

Email Address: _____

Employer Name: _____

Emergency Contact: _____ Phone Number: _____

Name Of Person Referred By: _____

Billing Instruction

Name of person
to be billed: _____ Relationship: _____

Address (if different): _____

Telephone: Home: _____ Business: _____ Cell: _____

Dental Insurance Company: _____

Subscriber ID: _____ Date of Birth: _____

Insurance Group Number: _____

Employer: _____

Are you covered by a second dental plan? Yes / No

If yes, Second Dental Insurance Company: _____

Subscriber ID: _____ Date of Birth: _____

Insurance Group Number: _____

I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. All accounts are subject to a finance charge computed on the unpaid balance 90 days and over. Maximum periodic rate and annual percentage rate are determined by the laws of the patient's state of residence. In the event a finance charge may be made on your account, the periodic rate is 1.5% and the annual percentage rate is 18%.

Patient Signature: _____
(If patient is a minor, parent or guardian signature, please)

POS Reorder # 1916057