Dr. Kenneth Ronzo's Patient Registration Form…..CONFIDENTIAL

Welcome to our practice!

Thank you for selecting our dental healthcare team. Please fill out this form completely in ink. If you have any questions or concerns, please do not hesitate to ask for assistance – we will be happy to help!

Date_____
Name_____ Date of Birth_____
First MI Last
Soc. Sec. #_____
Home Address_____ City_____ State_____ Zip_____
Home Phone_____ Work Phone_____ Cell Phone_____
Email address_____
Do you prefer to receive calls on: □ Home □ Work □ Cell
Emergency Contact _____ Relationship to self _____
Emergency Contact's Phone # _____
If you are a student, name of school/college _____

Who can we thank for referring you? _____

Responsible Party: (if self, indicate self)

Name of person responsible for this account_____ Relationship_____
Address_____ Home Phone_____
City, State, Zip_____ Driver's license #_____
D.O.B._____ is this person currently a patient in our office? □ Yes □ No
Employer_____ Work Phone # _____

Dental Insurance Information:

Name of policy holder_____
Relationship to patient_____ D.O.B._____ Soc. Sec. #_____
Insurance company_____ Insurance Id #_____ Group #_____
Ins. co. address_____ City_____ State_____ Zip_____
Ins. Company Phone number_____

Please continue… →

Dr.Kenneth Ronzos patient registration form continued……..**CONFIDENTIAL**

Do you have any additional insurance? □Yes □No If yes, complete the following:

Name of Insured_____

Relationship to patient_____ D.O.B._____ Soc. Sec. #_____
Employer_____ Date employed _____ Work phone_____
Insurance company_____ Insurance Id #_____ Group #_____
Ins. co. address_____ City_____ State_____ Zip_____

Please Review Our Policies and Sign:

1. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such dental care to third party payers and/or other health practitioners.
2. I authorize and hereby request my insurance company to pay directly to the dentist (or dental group) insurance benefits otherwise payable to me.
3. Should my insurance coverage pay less than the anticipated amount, I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents.
4. Full payment is expected at time of service unless other arrangements are made.
5. A service charge of 2.0% per month on the unpaid balance will be charged after 30 days.
6. If an appointment is broken or cancelled within 24 hours, a charge of $1.00 per minute of time scheduled will be applied to my account.
7. Returned checks are subject to a $35.00 service charge and will terminate my privilege to pay by check on future visits.
8. It is understood and agreed that any outstanding balance has to be referred to a collection agency or attorney for recovery and I will be fully responsible for all collection agency fees and attorney's fees.

I have read, fully understand and agree to abide by said policy:

Print Name_____ Date_____

Signature_____