Registration

RESPONSIBLE PARTY_____ BIRTHDATE_____

BILLING ADDRESS _____ SS#_____

CITY _____ STATE _____ ZIP _____

HOME# _____ WORK# _____ CELL# _____

REFERRED BY_____ EMAIL_____

PLEASE LIST ALL FAMILY MEMBERS FOR THIS ACCOUNT

FIRST NAME	LASTNAME	SEX	RELATIONSHIP	BIRTHDATE

DENTAL INSURANCE INFORMATION

SUBSCRIBER'S NAME_____ BIRTHDATE_____

INSURANCE NAME _____ SS#/ID#_____

GROUP#_____ UNION#_____ LOCAL#_____

EMPLOYER _____

ASSIGNMENT OF BENEFITS

I hereby authorize payment to dental benefits otherwise payable to me directly to Walker and Kraus D.D.S. PLLC

_____ _____

SIGNATURE OF SUBSCRIBER **DATE**

I authorize the release of any information necessary to process this claim

_____ _____

SIGNATURE OF SUBSCRIBER **DATE**

As a courtesy, this dental office will estimate your charges and insurance payments. It is only an estimate. It is subject to modification depending on unforeseen circumstances that may arise during the course of treatment, additional information, or the actions of your employer or your insurance carrier. Please understand that all dental services furnished are charged directly to the responsible party listed above. This office will help prepare the patient's insurance forms to assist in making collections from insurance companies and will credit such collections to the responsible party's account. Outstanding balances not paid by your insurance after sixty days will be your responsibility. All account balances aged ninety days will be charged 1% interest or 12% annually. Minimum monthly charge $.50

I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance on my account for any professional services rendered for myself and my family members listed above. I understand that my estimated portion of those fees is due on the day of service and that I may pay cash, check, Visa, MasterCard or care credit. Corrections to the estimate will be made after insurance claims have been processed. I certify that the information I have provided is true and correct to the best of my knowledge. I will notify you of any changes in the above information. In the event of default of payment, if litigation is necessary, I understand that I will be responsible for all legal and court costs including reasonable attorney fees.

_____ _____

SIGNATURE OR RESPONSIBLE PARTY **DATE**