ROBERT E. DERR, DDS
Family Dentistry

PATIENT REGISTRATION

PATIENT'S NAME: _____ Nickname: _____
Address: _____ Date of Birth: _____
_____ Home #: _____
_____ Cell #: _____

Email address: _____
Employer: _____ Work #: _____

Spouse's Name: _____ Date of Birth: _____
Spouse's Employer: _____ Work #: _____

If patient is a child:
Father's Name: _____ Mother's Name: _____
Employer: _____ Employer: _____
Work #: _____ Work #: _____

Name of person responsible for this account: _____

DENTAL INSURANCE:
Insurance Company: _____
Subscriber's Name: _____
Date of Birth: _____ ID #: _____ Group #: _____

Name and Phone # of 2 persons whom we may contact in case of emergency:
_____
_____

Name of previous dentist where records could be obtained, if necessary:
_____

Whom may we thank for this referral? _____

Our Payment Policy

PAYMENT IS DUE AS SERVICES ARE RENDERED. We will gladly file your insurance claim for you. A service charge of .66% per month (7.92% annually) will be automatically added to any balance over 60 days. A $25.00 fee will be charged on all returned checks.

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. If insured, I authorize any insurance payment to go directly to Dr. Robert Derr.

Date: _____ Signature: _____