

Robert Derr D.D.S.

# Patient Registration

Amy Chi D.D.S.

Family Dentistry

## Patient Information:

Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_

Address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

\_\_\_\_\_ Home #: \_\_\_\_\_

\_\_\_\_\_ Cell #: \_\_\_\_\_

Email address: \_\_\_\_\_ Work #: \_\_\_\_\_

Preferred method of appointment confirmation: text email call

Employer: \_\_\_\_\_

Spouse's Name (if applicable): \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Employer: \_\_\_\_\_ Work #: \_\_\_\_\_

If patient is a child:

Father's Name: \_\_\_\_\_ Mother's Name: \_\_\_\_\_

Employer: \_\_\_\_\_ Employer: \_\_\_\_\_

Name of person responsible for this account: \_\_\_\_\_

## Dental Insurance:

Insurance Company: \_\_\_\_\_ Subscriber's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

**Emergency Contact:** Name and # of whom we may contact in case of emergency:

\_\_\_\_\_

Previous Dentist/location where records could be obtained, if necessary:

\_\_\_\_\_

Whom may we thank for this referral? \_\_\_\_\_

Website  Google  Specialist  Insurance  Facebook  Instagram  Mpls/St Paul Mag  Location

**Our Payment Policy:** Payments are 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/Dr Chi.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_