Dr. Thomas G. Schell & Dr. Patrick C. Noble, PLLC
Family & Esthetic Dental Care

Patient Registration Form

NAME: _____ DATE: _____

How did you hear about our family dental practice? _____

Account Responsibility:

If the person responsible for this account is different than the patient or if the patient is a minor, the responsible party must fill out the section below. Otherwise, please skip to the section titled: "Insurance Information".

Name of responsible party: _____ Relationship to Patient: _____
Mailing Address: _____
Home Telephone _____ Work Telephone _____ Cell: _____
Employer: _____

Insurance Information:

Proof of insurance is required. Please give your insurance card to the front desk to make a photocopy.
Policy Holder Name: _____ Relationship to Patient: _____
Name of Employer: _____
If Student, name of school/college: _____
Insurance Company: _____Subscriber DOB: _____ Group # _____
Insurance Address: _____ Subscriber ID: _____

I authorize the dentist to release any information including the diagnosis and the records of any treatment or exam rendered to me for my child during the period of such dental care to third party payers and /or health practitioner. I authorize and request my insurance company to pay the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I will be responsible for payment of all services rendered on my behalf or my dependents.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.
Date: _____
Print Name: _____ Signature: _____

For Office Use Only

We attempted to obtain written acknowledge of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- o Individual refused to sign
- o Communication barriers prohibited the acknowledgement
- o An emergency situation prevented us from obtaining acknowledgement
- o Other (please specify)

Dr. Thomas G. Schell & Patrick C. Noble, PLLC
31 Old Etna Road, N1
Lebanon, NH 03766

OUR FINANCIAL POLICY

Thank you for choosing our office for your dental needs. We are committed to providing our patients with the best possible treatment and service. The following is a statement of our financial policy which we require that you read, agree to, and sign prior to any treatment.

- Payment is due at the time of service
- For your convenience we accept Visa, Mastercard, American Express, Discover, and Care Credit, as well as cash and personal checks
- As a courtesy to our patients, we also accept assignment of insurance benefits

REGARDING INSURANCE ASSIGNMENT:
The balance is your responsibility, whether your insurance company pays or not. We cannot bill your insurance unless you bring in all insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. The estimate provided by this office is considered as a guideline until the final insurance payment is received and the patient's account has been reconciled. This office can make no guarantee of the insurance payment as estimated. Claims are submitted promptly after treatment is rendered, and if not paid by patient's insurance company by the 61st day after treatment, will be billed in full to the patient. Our administrative staff prides itself on helping our patients maximize their benefits. We are always available to answer any of your questions.

MISSED APPOINTMENTS
Once an appointment has been made, please remember that this time has been specifically reserved for you. No charge will be made for rescheduling an appointment provided 24 hour notice is given. If you do cancel on short notice or give no notice, you will be required to put a deposit down towards future appointments.

FINANCIAL CONSENT
The patient (guardian) agrees to be fully responsible for total payment of procedures performed at this office, including any treatment not a benefit of any insurance the patient may have.

PHOTO CONSENT:
I consent to the taking of radiographs and/or photographs before and during treatment for diagnostic and educational purposes.

I CERTIFY THAT I HAVE READ, UNDERSTOOD, AND AGREE TO THIS. I HAVE RECEIVED A COPY OF THIS FINANCIAL POLICY AND AGREEMENT

Patient/Guardian Signature_____ Date _____