Dr. Peter Matkowsky

Patient Registration Form

Thank you for choosing our practice! We look forward to taking care of all your dental needs. Please fill out this form in ink only. If you have any questions regarding this form do not hesitate to ask for assistance. We will be happy to help.

(Please Print)

Patient Name: _____Name I go by:_____Date: _____

Last First Middle

SS#:_____ Birthdate:_____ SEX: Male Female

Marital Status: Single Married Divorced Widowed Partnered Spouse's Name: _____

Home Address: _____City/State/Zip: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____ Work Phone: _____

What is the best way to contact you? Home Work Cell Email (Please circle one)

Employer/School Name: _____ Occupation: _____

Address: _____ City/State/Zip: _____

How did you hear about our office, or who may we thank for referring you? Sign Yellow Pages Powhatan Today

Referral (name of patient) _____

***Please list an Emergency Contact (Name/Phone):_____**

RESPONSIBLE PARTY

(Fill this section out if different than above)

Name of person responsible for account: _____ Relationship: _____

Birthdate: _____ Age: _____ SS#:_____ Phone: _____

Address: _____ City/State/Zip: _____

Employer Name: _____ Work Phone: _____

PRIMARY DENTAL INSURANCE INFORMATION

Subscriber's Name: _____ Relationship:_____

Birthdate: _____ SS#:_____ ID#:_____

Insurance Company: _____ Group #:_____

Insurance Phone#:_____ Insurance Address: _____

Employer's Name: _____ Work Phone: _____

SECONDARY DENTAL INSURANCE INFORMATION

Do you have secondary dental insurance? YES NO

Subscriber's Name: _____ Relationship:_____

Birthdate: _____ SS#:_____ ID#:_____

Insurance Company: _____Group #:_____

Insurance Phone#: _____Insurance Address: _____

Employer's Name: _____ Work Phone: _____

_____**Secondary Insurance:**

Our office does not file secondary insurance. This is the responsibility of the patient. However, we will assist you by filing your Primary insurance for you. When estimating patient portions secondary insurance will **not** be calculated in determining your payment due. However, we will provide you with the necessary paperwork in order to make filing your claim more convenient.

How to file the claim. . .

As a courtesy, we will provide you with a completed secondary insurance claim form. Once you receive the Explanation of Benefits (EOB) from your primary insurance carrier you will have all materials needed to submit to your secondary insurance carrier. Simply attach a copy of the primary EOB to the secondary claim form and submit to the claims mailing address (found in upper left-hand corner of claim form).

_____**A 48-hour cancellation notice is required for appointments.**

Time is valuable for both you and us. There will be a *minimum* fee of **$50.00** assessed for all appointments cancelled less than 48 hours prior to appointments. You will be required to pay this fee prior to rescheduling this appointment. Please allow 2 working days notice to reschedule an appointment. Changes in appointments scheduled on Mondays require notification to our office by noon on the preceding Thursday. Please help us serve you better by keeping scheduled appointments.

_____A legal parent or guardian must accompany any patient under the age of 18 for each visit. Parent or guardian must remain in the waiting area during patient's appointment until treatment has been completed and the patient has been dismissed by the doctor.

_____We gladly accept the following forms of payment: Cash, Check, Money Order, Visa, MasterCard and Discover. Out of state checks are **not** accepted.

_____Financing is also available through Chase Health Advance and Care Credit. Should you need assistance with applying for these services, please see one of our office staff for assistance.

_____Balances must be paid in full before any future appointments can be made or services can be rendered.

_____Returned check fees – The minimum charge for an NSF check is **$50.00**. Any additional charges incurred during the recovery of the check are the responsibility of the patient.

_____For all major dental work, we require a *minimum* deposit of **$100.00**, which will be applied to the cost of your procedure. This will enable us to reserve the allotted time with the doctor.

Authorization for treatment – Acknowledgement of responsibility

I authorize and give consent to perform dental services agreed upon between doctor and patient and/or parent or guardian to be necessary or advisable including the use of local anesthesia and other medication as indicated. I hereby authorize payment directly to the dental office of the group insurance benefits otherwise payable to me. I hereby acknowledge that I am fully responsible for the balance due for any services rendered regardless of my insurance coverage and status. I certify that the information I have given is correct and current to the best of my knowledge.

_____	_____	____/____/____
Signature of patient/ legal guardian	Relationship to patient	Date