David Polhemus DDS
8001-211 Creedmoor Rd, Raleigh, NC 27613 (919) 870-7104

First Name: _____ Last Name: _____ Middle Initial: _____

Preferred Name: _____ Social Security #: _____ Birth Date: _____

Address: _____ City _____ State _____ Zip _____

Phone: Home_____ Work _____ Cell _____ Email _____

What method would you like us to use to confirm appointments: Phone Text Email (*please circle all that apply)*

For email communication I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to move forward to allow email communications to occur. Yes or No (*please circle)*

Sex: O Male O Female Marital Status: O Married O Single O Divorced O Separated O Widowed

Person Responsible for account _____ Relationship _____

DENTAL INSURANCE INFORMATION

Employer _____ Insurance Co. Name: _____

Insured's Name: _____ Insurance Address: _____

Insured's Social Security #: _____ Insurance Phone#: _____

Insured's Birthdate: _____ Group Number: _____

Relationship to patient: _____ Subscriber ID: _____

Who may we thank for referring you to our office? _____
Person to contact for emergency: Name _____ Phone# _____

DENTAL HISTORY

When was your last dental check-up and cleaning? _____

When was your last x-rays taken: Bitewings _____ Full Mouth Series/Panoramic _____ _____

Have you ever had: Orthodontic Treatment …… Yes No Periodontal Treatment …… Yes No

Are you happy with the appearance of your smile/teeth? If not, Why? _____

OFFICE POLICIES

-Payment in full is due at initial visit (cash, personal checks, VISA, MASTERCARD, AMERICAN EXPRESS & CARE CREDIT) (If you have insurance, we will file the claim and your insurance company will reimburse you.)

- There is a $35 charge on all returned checks.

- 24 hour notice is required for canceling or changing an appointment. There is an $85 charge for broken appointments and short notice cancellations. There is a $125 charge for appointments that were scheduled for greater than 1 hour in length.

- For procedures involving multiple appointments, half of the total fee is due on first appointment and the remainder upon completion of procedure.

- After insurance coverage is verified, your deductible and any co-payments are due at each visit. (*Co-payments are only estimates of coverage and are not a guarantee of payment.)* You are responsible for all charges not covered by insurance.

- This office does not file secondary insurance claims or accept them as payment.

- You are responsible for all charges regardless of insurance coverage. Claims not paid after 30 days will be billed to you for payment.

- A finance charge of 1.5%/month (18%APR) is added to all balances over 30 days old.

I have read and understand the above policies and my financial obligation to this office and agree to all the terms.

Signature _____ Date _____

PATIENT REGISTRATION