PATIENT REGISTRATION

First Name:			
		Last Name:	Middle Initial:
Patient Is: Policy Holder	Responsible Party	Preferred Name:	
Responsible Party (if som	neone other than the patient) —————————————————————————————————————	
First Name:		Last Name:	Middle Initial:
Address:		Address 2:	
City, State, Zip:			Pager:
Home Phone:	Work Pho	ne;	Ext: Cellular:
Birth Date:	Soc S	ec;	Drivers Lie:
Responsible Party is also a P	olicy Holder for Patient	Primary Insurance Policy Holder	Secondary Insurance Policy Holder
Patient Information			
Address:		Address 2:	
City:		State / Zip:	Pager:
Home Phone:	Work Phot	ne:	Ext: Cellular:
Sex: Male	Female	Marital Status: Married	Single Divorced Separated Widowed
Birth Date:	Aį	ge: Soc Sec:	Drivers Lic:
E-mail:		I would like to	receive correspondences via e-mail.
	Section 2		Section 3
Employment Full Time	e Part Time	Retired	Emergency Contact
Student Status: Full Time	/111 - 120 1 - 120 1 - 120 1	5. 86	Care Credit Number Emergency Contact #
Student Status: Full Time Medicaid ID:	Pref. I		Emergency Contact # credit card #
Student Status: Full Time Medicaid ID: Employer ID:	Pref. I Pref. Pha	rmacy:	Emergency Contact #
Student Status: Full Time Medicaid ID:	Pref. I Pref. Pha		Emergency Contact # credit card #
Student Status: Full Time Medicaid ID: Employer ID:	Pref. I Pref. Pha Pre	rmacy:	Emergency Contact # credit card #
Student Status: Full Time Medicaid ID: Employer ID: Carrier ID:	Pref. I Pref. Pha Pre	rmacy: f. Hyg;	Emergency Contact # credit card #
Student Status: Full Time Medicaid ID: Employer ID: Carrier ID: Primary Insurance Inform	Pref. I Pref. Pha Pre	rmacy: f. Hyg;	Emergency Contact # credit card # Cell phone #
Student Status: Full Time Medicaid ID: Employer ID: Carrier ID: Primary Insurance Inform Name of Insured:	Pref. I Pref. Pha Pre	rmacy: f. Hyg: Relationship Insured Birth Date:	Emergency Contact # credit card # Cell phone #
Student Status: Full Time Medicaid ID: Employer ID: Carrier ID: Primary Insurance Inform Name of Insured: Insured Soc. Sec:	Pref. I Pref. Pha Pre	rmacy: f. Hyg: Relationship Insured Birth Date:	Emergency Contact # credit card # Cell phone # p to Insured: Self Spouse Child Other
Student Status: Full Time Medicaid ID: Employer ID: Carrier ID: Primary Insurance Inform Name of Insured: Insured Soc. Sec: Employer:	Pref. I Pref. Pha Pre	rmacy: f. Hyg: Relationship Insured Birth Date: Ins. 0	Emergency Contact # credit card # Cell phone # p to Insured: Self Spouse Child Other Company:
Student Status: Full Time Medicaid ID: Employer ID: Carrier ID: Primary Insurance Inform Name of Insured: Insured Soc. Sec: Employer: Address:	Pref. I Pref. Pha Pre	rmacy: f. Hyg: Relationship Insured Birth Date: Ins. C	Emergency Contact # credit card # Cell phone # p to Insured: Self Spouse Child Other Company: Address:
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Student Status: Full Time Medicaid ID: Employer ID: Carrier ID: Primary Insurance Inform Name of Insured: Insured Soc. Sec: Employer: Address: Address 2: City, State, Zip:	Pref. I. Pref. Pha Pre nation	rmacy: f. Hyg: Relationship Insured Birth Date: Ins. C A City, S	Emergency Contact # credit card # Cell phone # p to Insured: Self Spouse Child Other Company: Address:
Student Status: Full Time Medicaid ID: Employer ID: Carrier ID; — Primary Insurance Inform Name of Insured: Insured Soc. Sec: Employer: Address: Address: Address 2: City, State, Zip: Rem. Benefits:	Pref. I. Pref. Pha Pre nation	Relationship Insured Birth Date: Ins. C A City, S cem. Deduct:	Emergency Contact # credit card # Cell phone # p to Insured: Self Spouse Child Other Company: Address:
Student Status: Full Time Medicaid ID: Employer ID: Carrier ID; — Primary Insurance Inform Name of Insured: Insured Soc. Sec: Employer: Address: Address 2: City, State, Zip: Rem. Benefits: — Secondary Insurance Info	Pref. I. Pref. Pha Pre nation	Relationship Insured Birth Date: Ins. C A City, S cem. Deduct:	Emergency Contact # credit card # Cell phone # p to Insured: Self Spouse Child Other Company: Address: Address 2: State, Zip:
Student Status: Full Time Medicaid ID: Employer ID: Carrier ID: Primary Insurance Inform Name of Insured: Insured Soc. Sec: Employer: Address: Address: Address 2: City, State, Zip: Rem. Benefits: Secondary Insurance Info	Pref. I. Pref. Pha Pre nation	Relationship Insured Birth Date: Ins. C A City, S cem. Deduct: Relationship Insured Birth Date:	Emergency Contact # credit card # Cell phone # p to Insured: Self Spouse Child Other Company: Address: Address 2: State, Zip:
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Student Status: Full Time Medicaid ID: Employer ID: Carrier ID: Primary Insurance Inform Name of Insured: Insured Soc. Sec: Employer: Address: Address 2: City, State, Zip: Rem. Benefits: Secondary Insurance Info Name of Insured: Insured Soc. Sec: Employer: Address:	Pref. I. Pref. Pha Pre nation	Relationship Insured Birth Date: Ins. City, S City, S Relationship Insured Birth Date: Relationship Insured Birth Date:	Emergency Contact # credit card # Cell phone # p to Insured: Self Spouse Child Other Company: Address: Address 2: State, Zip: p to Insured: Self Spouse Child Other Company: Address 2:

Reinecker Dental LLC MEDICAL HISTORY Birth Date:

Patient Name:

Date Created:

Date:

Averyou ever had a serious head or neck injury? Yes No If yes Ye	Ave you see' had a serious head or neck injury? Ves No If yes 17 yes 18 or you taking any medications, pills, or drugs? Ves No If yes 18 or you take, or have you taking any medications, pills, or drugs? Ves No If yes 18 or you was entered and the provided of the	lave you ever been hospit			Yes No	If yes	,			
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re you taking any medications, pills, or drugs? Yes No If yes 1	The you taking any medications, pills, or drugs? Yes No If yes 10 you take, or have you taking any medications, pills, or drugs? Yes No If yes Yes No If	lave you ever had a serio	us head or neck i	njury?						
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REINECKER DENTAL GROUP

GENERAL AND COSMETIC DENTISTRY

Knowing Your Insurance Coverage

Reinecker Dental Group is committed to providing our patients with excellent dental care to ensure good overall health. We are happy to work with your dental insurance, should you have it. The following is to help better serve you.

With the multitude of insurance companies and different policies within each one, it is imperative for you, as the patient, to know and understand your dental coverage.

Reinecker Dental Group may look into your insurance as a courtesy and provide you with any available information we may find.

In the end, educating yourself about your insurance benefits ensures that you will not be unexpectedly billed for services you have received from our office.

As always, we will do our best to assist with any service and insurance related questions.

Thank you for your support, understanding and cooperation.

Sincerely,

Reinecker	0	ental	Group
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By signing below, I agree that I understand my insurance plan coverage and that I wil	I be
responsible for any services/fees that my plan does not cover.	

Signature	Date
Signature	Date

REINECKER DENTAL GROUP

GENERAL AND COSMETIC DENTISTRY

Written Financial Policy

Thank you for choosing *Reinecker Dental Group* for your dental care! Our mission is to exceed the expectations of our community and patients, providing them with the proper education, caring nature and dental treatment everyone deserves. We understand an important part of the goal is making the financial aspect of one's optimal care as easy and manageable as possible. Therefore, we offer several payment options:

- · Cash, check, credit cards
- Convenient Monthly Payment Plans with CareCredit®
 - No interest for 12 months (application/qualification necessary)
 - No annual fees or pre-payment penalties
 - Allows you to pay over time
- Treatment plans that require 2 or more appointments may qualify for alternate payment arrangements at the discretion of Reinecker Dental Group.

At Reinecker Dental Group, we provide our patients with exceptional treatment in good faith that <u>full</u> <u>payment will be received at the completion of such treatment</u>. Should you decide to discontinue treatment prior to completion, your refund will be determined upon review of the case.

For patients with dental insurance, we are happy to work with your carrier to maximize your benefits. We will directly bill your insurance company for re-imbursement of treatment. Subsequently, you are responsible for any deductible and co-insurance you may have at time of service.

If you have any questions, please do not hesitate to ask! We are here to make your dental experience as comfortable and easy as possible!

By signing below, I agree that am financially res	sponsible for all services/fees incurred to my account.
Signature	Date

- > A \$40.00 charge will be applied for all returned checks
- A \$50.00 charge will be applied to a patient who misses or cancels more than 2 appointments in a calendar year without 24 hour notice.