# *Mengedoth Dental, PC*

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## Patient Registration

Please take a moment to enter or update your information to help us ensure the quality of your care is excellent.

**Chart#:** _____
FOR OFFICE USE ONLY

**Patient Name:** _____ _____ ___ _____
Last First MI Preferred Name

**Title:** _____ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

**Birth Date:** _____ **SS#:** ___-__-____ **Prev. Visit:** _____

**Email Address:** _____ **Best time to call:** _____

**Phone:** _____ _____ _____ _____ _____ _____
Home Mobile Work Ext Fax Other

**Address:** _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

**Preferred appointment times:**

☐ Mon ☐ Tue ☐ Thur ☐ Fri ☐ Morning ☐ Afternoon ☐ Any time

**I prefer to have my appointments confirmed at/via (please select 2):**

☐ EMail ☐ Cell ☐ Text ☐ Home ☐ Work

Name of person, office, or other source referring you to our practice:

_____

**In the event of an emergency, whom should we contact?**
**Please include: His/Her Name, Relationship, All telephone numbers (Cell, Work, Home)**

_____

_____

## Spouse or Responsible Party Information

**The following is for:** ◯ the patient's spouse ◯ the person responsible for payment ◯ both ◯ neither-not applicable

**Name:** _____ _____ ___ _____
Last First MI Preferred Name

**Title:** _____ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

**Birth Date:** _____ **Email Address:** _____

**Phone:** _____ _____ _____ _____ **Best time to call:** _____
Home Mobile Work Ext

**Address:** _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

## Financial Responsibility

By signing this statement, I am agreeing to the following:
I understand that the responsibility for payment for dental services provided in this office for my dependents and me is my responsibility. I hereby authorize payment of my dental insurance benefits directly to Daniel L. Mengedoth, DDS, Ltd. If other arrangements have been made, as is the case with certain insurance plans wherein payment goes directly to me, I understand that I must pay in full on the day services are rendered. I also understand that my dental insurance carrier or payer of my dental benefits may pay less than the actual bill for services, and that I am financially responsible for payments in full of all accounts.

☐ ***I have read the above conditions of treatment and payment and agree to their content.**

## Cancellation and Broken Appointment Policy

We understand that illness, emergencies, flat tires, and bad weather do occur. We ask our patients to give us 2 business days notice whenever possible, if they cannot keep an appointment. This allows us time to fill our schedule with other patients who may be waiting.

Policy and Fees:

Cancellation or rescheduling of an appointment with 2 business days or more notification No Charge

Emergency cancellations are accepted only for illness, illness of a family member or death in the family. We ask that whenever possible you contact us by 9:00am the day of your appointment if you are not feeling well and unable to make it to your scheduled appointment.

Failure to give 2 business days notice:

-There will be a charge of $25 per 30 minutes of scheduled time for a broken appointment.

Definition of Broken Appointment: A broken appointment is when you

*Cancel or reschedule an appointment with less than 2 business days notice for a non-emergency which include; vacations, preplanned medical appointments, family events, parties, sports events, lack of babysitter or anything that is not designated as an emergency (see above).
*Do not show up for the scheduled appointment.

Our number one priority is our patients overall health. Providing treatment in a timely manner is critical to accomplish that goal. Our other goal is to keep the cost of treatment down. The appointment you schedule for treatment is reserved for you and your treatment only. When you fail to keep your appointment without providing us adequate notice, this adds to the overall cost of care, as trained professionals and dental facilities are not being utilized.

We appreciate your understanding and consideration regarding our appointment policy and if you have any questions or concerns, never hesitate to contact as us at Mengedoth Dental.

☐ ***I have read and understand the cancellation and broken appointment policy.**

## Employment Information

**The following is for:** ◯ the patient ◯ the person responsible for payment ◯ both ◯ not applicable

**Employer Name:** _____ **Phone:** _____

**Employer Address:** _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

## Primary Insurance Information

**Primary Dental Insurance:**

**Name of Insured:** _____ _____ ____
Last First MI

**Insured's Birth Date:** _____ **ID #:** _____ **Group #:** _____

**Insured's Address:** _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

**Insured's Employer Name:** _____

**Employer Address:** _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

**Patient's relationship to insured:** ◯ Self ◯ Spouse ◯ Child ◯ Other

**Insurance Plan Name:** _____

**Insurance Address:** _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

**Primary Medical Insurance:**

**Name of Insured:** _____ _____ ____
Last First MI

**Patient's relationship to insured:** ◯ Self ◯ Spouse ◯ Child ◯ Other

**Insurance Plan Name:** _____

## Secondary Insurance Information

**Secondary Dental Insurance:**

**Name of Insured:** _____ _____ ____
Last First MI

**Insured's Birth Date:** _____ **ID #:** _____ **Group #:** _____

**Insured's Address:** _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

**Insured's Employer Name:** _____

**Employer Address:** _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

**Patient's relationship to insured:** ◯ Self ◯ Spouse ◯ Child ◯ Other

**Insurance Plan Name:** _____

**Insurance Address:** _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

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**Response Date:** ____/____/_____