REGISTRATION A

WELCOME TO FIANT DENTAL. WE'RE HAPPY YOU'VE CHOSEN OUR OFFICE FOR YOUR DENTAL CARE. PLEASE TAKE A FEW MINUTES TO TELL US ABOUT YOURSELF, SET-UP YOUR ACCOUNT, AND ESTABLISH YOUR NEW DENTAL RECORD.

PERSONAL INFORMATION

Full Legal Name: _____

Preferred Name: _____ Pronouns: _____

Date Of Birth: _____ SSN: _____

Address: _____

City, State, Zip: _____ Phone Number: _____

Email: _____

EMPLOYMENT INFORMATION

Employer: _____ Occupation: _____

Address: _____

City, State, Zip: _____ Work Phone: _____

PRIMARY DENTAL INSURANCE INFORMATION

Insurance Company Name: _____

Group Plan #: _____ Policy Holder's Name: _____

Policy Holder's Id #: _____ Policy Holder's Date Of Birth: _____

This Person Is My: ☐ Self ☐ Partner/Spouse ☐ Parent/Guardian ☐ Other: _____

Employer of insured: _____

Address: _____

City, State, Zip: _____ Work Phone: _____

Are you covered by more than 1 dental insurance plan? ☐ No ☐ Yes

EMERGENCY CONTACT INFORMATION

Name: _____ Relation: _____

Address: _____

City, State, Zip: _____ Phone Number: _____

HOW DID YOU HEAR ABOUT OUR OFFICE?

_____

_____

Referral name: _____

REGISTRATION B

FINANCIAL POLICY FOR PATIENTS WITH INSURANCE

As a convenience, Fiant Dental files dental insurance claims on your behalf. We're happy to help with estimating your benefits. However, it's your responsibility to know the exact benefits of your plan and to manage your coverage.

If Fiant Dental is unable to collect benefits from your insurance company after two attempts, you will be responsible for the entire account balance. Payment is due upon receipt of your statement.

Annual deductibles and estimated patient portions are due the day of your appointment. Sometimes your actual insurance coverage will be different than the amount your insurance plan may have estimated. Once your insurance company pays its share, you may still have a balance due. Payment is due upon receipt of your statement.

Your signature on this Financial Policy Form will serve as an Assignment of Benefits and authorize your insurance plan to make payments directly to Fiant Dental.

FINANCIAL POLICY FOR PATIENTS WITHOUT INSURANCE

Payment is due in full on the day of service. Please indicate your payment preference:

- ☐ Cash or Check
- ☐ Credit Card (Visa, MasterCard, American Express, Discover)
- ☐ Care Credit*

*Financing with a 90 day no-interest plan, or longer terms at low-interest rates. Applying is quick and easy. Approvals are received within minutes. Ask our team for an application.

FINANCE & BILLING CHARGES

Delinquent accounts increase the cost of care for all our patients. Please help keep care affordable by maintaining an account in good standing. A monthly finance charge of 1.5% (Annual Percentage Rate 18%) is calculated on account balances greater than 30 days old. A billing charge of $5.00 per statement is calculated on account balances below $100.00.

CONSENT FOR CARE

Your signature below authorizes Fiant Dental to diagnose, administer medications, and perform preventive and therapeutic procedures that are necessary for your dental health.

MISSED APPOINTMENTS

Your appointment reserves our office and professional staff exclusively for you. Missed appointments increase the cost of care for all our patients. Appointments canceled with less than 24 hours notice, or missed completely, are billed directly to you at $85/hour.

I AGREE

I've read and agree to the above policies.

PATIENT OR GUARDIAN SIGNATURE _____ DATE _____