Stratford Dental
REGISTRATION FORM

Mr./Mrs./Miss/Dr. ______________________________ (Nickname)____________ Date of Birth ________
Full Name (please print)
Address____ SS#______________________________
City ____ State ______________ Zip _______________
Home Phone ___________________ Work Phone ____________________ Cell Phone ___________________
Email ____ Receive Text Messages? Y N
(By sharing the above information, you agree that Stratford Dental may use this information as a means to communicate with you)

Is there dental Insurance for this patient? ____________ Employer ___________________________________
Full Name of Employee ____________________________ ID/SS#______________ Birth Date ___________
Whom may we thank for referring you to our office? ____
We would like to get to know our patients. Please tell us something about yourself (e.g. Church, Community activities, hobbies or interests): ____

Complete this section ONLY if the patient is a minor
Full name of Parent or Legal Guardian ____
I authorize treatment for this patient ______________________________________ (Signature of Legal Parent/Guardian)

Consent for Use and Disclosure of Health Information
Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

Consent to communicate with another person(s): If you would like us to communicate with a significant other(s) regarding your protected health information please indicate on the line below:

Personal Representative Name: ___________________________ Relationship to patient: _________________

Office Policy: You will be expected to pay any deductible and co-payment, as best as we can estimate, on the day services are provided. If needed or no insurance, a payment plan can be arranged in advance for the remainder of the estimated out of pocket expenses. Another option available to you is through Care Credit. It must be fully understood that the contract is between you and your insurance company and you are fully responsible for any amount not paid by your insurance.

If your insurance company makes any check payable to you and your account with us has a balance, you will sign the check and make it payable to Stratford Dental, P.C.

Cancellations- We require at least 24 hours notice to change your appointment; otherwise there will be a cancellation fee of $100.00 charged to your account.

Finance Charge- A .75% monthly finance charge will be added to all overdue accounts.

Delinquency- If your account falls into delinquency, you agree to pay any and all collection agency charges (33% of the principal amount), attorney and court fees.

Signature: ____ Date: ________________
(By signing, you acknowledge receipt of our Notice of Privacy Practices and insurance assignment if applicable.
You are entitled to a copy of this Consent and Office Policy)