Patient Registration

Patient Information Below

Patient's Name:	**[] Male [] Female**
Preferred Name:	**Date of Birth:**
Marital Status:	**Social Security #:**
Address:	**Home Phone: ( )**
City: State: **Zip:**	**Cell Phone: ( )**
Email Address:	**Student Status: []Full time []Part time**
Relationship to Policy Holder:	

PRIMARY INSURANCE - *Policy Holders Information Below*

Policy Holder's Name:	**Insurance Company:**
Date Of Birth:	**Member ID#:**
Social Security #:	**Group#:**
Employer:	**Phone#:**

SECONDARY INSURANCE ***- Policy Holders Information Below***

Policy Holder's Name:	**Insurance Company:**
Date Of Birth:	**Member ID#:**
Social Security #:	**Group#:**
Employer:	**Phone#:**

Who referred you to our office?

At Westlake Dental Associates we are committed to providing you with the proper treatment while being aware of your financial responsibilities. Treatment plans will be submitted to you with your expected insurance coverage prior to treatment being completed , so that you are aware of any co-payment or deductibles for yourself or dependents. Payment plans are offered through Care Credit for those who desire a interest free or extended payment options. As a courtesy we will file your dental insurance to maximize your benefits while decreasing your out of pocket expense. Your medical insurance will **ONLY** be used in circumstances where it is considered medically necessary and financially benefits you. Regardless of any medical explanation of benefits (EOB'S) you receive, **YOU WILL NOT BE FINANCIALLY RESPONSIBLE FOR ANY FEES BEYOND YOUR NORMAL DENTAL INSURANCE COPAYS.**
Please let the front desk staff members if you have any questions.
Signing below indicates that you have read and agree to our payment policy.

Signature :____
Date:____________________________