# PATIENT REGISTRATION

## Patient Information

First Name: _____ Last Name: _____ Middle Initial: _____

Preferred Name: _____ Sex: ☐ Male ☐ Female Patient is : ☐ Policy Holder ☐ Responsible Party

Birth Date: _____ Age: _____ SS#: _____

Address: _____ Address 2: _____

City: _____ State / Zip: _____

Home Phone: _____ Cell Phone: _____ Email: _____

My preferred method for appointment confirmation: ☐ Text ☐ Email ☐ Other: _____

### Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Preferred Hygienist: _____

Preferred Doctor: _____

Preferred Pharmacy: _____

### Section 3

Emergency Contact: _____

Emergency Phone Number: _____

Referred by: _____

## Responsible Party *(If someone other than the patient)*

First Name: _____ Last Name: _____ Middle Initial: _____

Birth Date: _____ SS #: _____

Address: _____ Address 2: _____

City, State, Zip: _____ Home Phone: _____ Cell Phone: _____

☐ Responsible Party is the Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

## Primary Insurance Information

Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Name of Insured: _____ Insured Birth Date: _____

Insured SS #: _____ Ins. Company: _____

Employer: _____ Address: _____

Address: _____ City, State, Zip: _____

City, State, Zip: _____ ID#: _____

Group #: _____

## Secondary Insurance Information

Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Name of Insured: _____ Insured Birth Date: _____

Insured SS #: _____ Ins. Company: _____

Employer: _____ Address: _____

Address: _____ City, State, Zip: _____

City, State, Zip: _____ ID#: _____

Group #: _____

# Altitude Dental

Dr. Andrew Freund, DDS
Dr. Kenneth Van Kirk, DDS

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I _____ have reviewed / received a copy of this office's Notice of Privacy Practices.

_____
(Print Full Name)

_____
(Signature)

_____
(Date)

## PAYMENT POLICY

**Payment in full is required when services are rendered unless prior arrangements have been made.** We accept major credit cards, cash or check. If you need to establish a payment plan, we accept Care Credit. You may apply with them by calling (800) 859-9975 or go online to www.carecredit.com. We honor the 6 month plan with 0% interest to you. You must arrange this payment plan prior to your visit.

If you have insurance: **WE ARE NOT CONTRACTED INSURANCE PROVIDERS,** but we will be glad to submit a claim on your behalf as long as we have a copy of the card and date of birth of subscriber.

Accounts not paid within 45 days of the date of the invoice are subject to a 1.25% monthly finance charge.

Should your account be referred to a **third party collection agency** you agree to pay all **collection fees, attorney fees** and **court costs**.

Signature: _____ Date: _____