RENTON SMILE
DENTISTRY

1107 SW Grady Way, Suite 250
Renton, WA 98057
(425) 687-8860

Primary Insurance:

Subscriber's Name_____SS#_____

Relationship of Patient: ☐ Self ☐ Spouse ☐ Child Birthdate_____

Insurance Company _____Group# _____

Address_____Phone _____

Secondary Insurance:

Subscriber's Name_____SS#_____

Relationship of Patient: ☐ Self ☐ Spouse ☐ Child Birthdate _____

Insurance Company_____Group# _____

Address _____Phone _____

AUTHORIZATION FOR RELEASE OF INFORMATION: (All patients/guarantors must sign) I certify that the above information is correct. I authorize release of any information relating to my dental claims. I understand that I am responsible for all costs of dental treatment. I hereby authorize payment of the group insurance benefits otherwise payable to me directly to Renton Smile Dentistry.

PERMISSION FOR TREATMENT: (All patients/guarantors must sign) I hereby give my permission to Renton Smile Dentistry dentists to provide dental treatment as deemed necessary.

PAYMENT AGREEMENT: (All patients/guarantors must sign) I understand that my Insurance Policy is between the insurance company and myself and I am liable to Renton Smile Dentistry for services rendered. I also understand I will be furnished with an **estimate** regarding my insurance benefits at the onset of treatment. I agree to pay Renton Smile Dentistry for all dental treatment at the time of service. I promise to pay my account until my balance has been paid in full. Should my account become past due, I will be charged 1.5% per month interest with $25.00 late charge fee on the overdue amount. I also understand that should my account become delinquent, it may be turned over for collection, including any attorney's fees incurred.

Patient Signature _____ Date_____

Please remember that once an appointment has been made, this time is reserved specially for you. No charge will be made for rescheduling an appointment, provided early notice of *at least* 1 business day is given. Otherwise minimum charge of $50 per hour scheduled may be incurred. We reserve the right to not reschedule your appointment.

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ADULT REGISTRATION FORM

Patient's Name _____ Preferred Name _____

Birthdate _____Age _____Gender: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated
Social Security Number _____

Address _____City _____State_____Zip_____

Phone Number _____Cellular phone number_____

Fax Number _____ Email _____

Employer _____Position _____How Long? _____

Employer Address _____Phone _____

City_____State_____Zip_____

Spouse's Name _____SS# _____Birthdate_____

Phone Number _____Cellular Phone number _____

Spouse's Employer _____Phone _____

Employer Address _____

City _____State _____Zip_____

Who should we notify, other than spouse, in case of emergency?

Name _____Relationship_____
Address _____Phone_____
City _____State_____Zip_____
Previous Dentist _____Phone _____

How did you hear about our office?
Insurance referral ☐ ☐ Family Member: _____
Phone Book – Yellow Book ☐ ☐ Doctor's Office: Dr._____
Yelp ☐ ☐ Website
Other: (Please specify) ☐ _____

Payment information: ***All services must be paid by cash, check or credit card as each service is provided.*** Patients with insurance or other coverage must complete all required information.

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(Please continue on the back side)