

CRAIG R. CAMERON, DDS, PLC
ADULT REGISTRATION
(Confidential)

DATE: _____

PATIENT INFORMATION

Name of Patient _____
Last Name First Name Initial
Sex ___M___F Age _____ Birthdate _____ Single ___ Married ___ Widowed ___ Divorced ___
Home Address _____
Street City State Zip
Patient Employed By _____ Occupation _____
Business Address _____ Business Phone _____
Person Financially Responsible _____
Billing Address _____
Street City State Zip
Home Phone _____ Work Phone _____ Cell _____
Whom may we thank for referring you? _____

PRIMARY DENTAL INSURANCE INFORMATION

Subscriber Name _____
Last Name First Name Initial
Relation to Patient _____ Birthdate _____ Soc. Sec. # _____
Address (if different from patients) _____
City _____ State _____ Zip _____
Subscriber Employed by _____ Occupation _____
Subscriber Address _____ Business Phone _____
Dental Insurance Company _____
Contract # _____ Group # _____ Subscriber # _____

SECONDARY DENTAL INSURANCE INFORMATION

Subscriber Name _____
Last Name First Name Initial
Relation to Patient _____ Birthdate _____ Soc. Sec. # _____
Address (if different from patients) _____
City _____ State _____ Zip _____
Subscriber Employed by _____ Occupation _____
Subscriber Address _____ Business Phone _____
Dental Insurance Company _____
Contract # _____ Group # _____ Subscriber # _____

EMERGENCY CONTACT

In the event of an emergency, whom should we contact?

Name _____ Relationship _____ Phone _____
Name _____ Relationship _____ Phone _____

INSURANCE ASSIGNMENTS

If this office is unable to accept your insurance company's assignment, it does not absolve the patient of full responsibility for the charges in full for treatment rendered. The estimate provided by this office is considered as a guideline until the final insurance payment is received and the patient's account has been reconciled. This office can make no guarantee of the insurance payment as estimated. The agreed upon payment plan for the patient's estimated portion must be kept current or the assignment will be cancelled and the full amount will become due and payable. Claims are submitted promptly after treatment is rendered, and if not paid by patient's insurance company by the 91st day after treatment, will be billed in full to the patient. Our administrative staff prides itself on helping our patients maximize their benefits. We are always available to answer your questions.

I, the undersigned, have insurance with _____
Name of Insurance Company

And assign directly to Dr. Craig R. Cameron all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

Signature of Insured

FINANCIAL AGREEMENT

Be advised the policy of this office is interest of 1.5% per month (18% ANNUAL PECENTAGE RATE) will be applied to all accounts over 60 days.

I, acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that I am responsible for all fees and services rendered for treatment. I accept full financial responsibility for all charges not covered by insurance.

Signature of Insured