CONTEMPORARY FAMILY DENTAL CARE **DR. C. TIMOTHY LIPP, D.M.D.**

REGISTRATION

Date: ______ Patient name: _________________________ name you wished to be called:______

Home street address: ______________________________ Phone #:___________________________

City: ___________________________________ State______________ Zip code: ________________

Mailing address if different from above: _____________________ State: _______Zip code: ________

Sex: M or F Age: _____ Birth Date: _________ Single Married Widowed Separated Divorced

Patient S S #:_____________________ Occupation: ______________Employer:_________________
Work Phone #:____________________

Spouse name: _______________________ Birth date: _________ SS#:__________________________

Occupation: ____________________________ Spouse employer: _______________________________

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IN CASE OF EMERGENCY PLEASE CONTACT:
Name: ________________________________Relationship to you:___________________________
Address and phone number of Emergency Contact Person___________________________________
Who may we thank for sending you here? ____
Who is responsible for this account? _______________________Relationship to patient____________

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Insurance Company of Patient:________________________________Group number:____________
Is patient covered by Additional Insurance? YES NO, if yes, Subscriber's name:________________
Subscriber's birth date:________Subscriber's SS #:__________ Relationship to patient:___________
Insurance Company: ____________________________________ Group number: ________________

ASSIGNMENT AND RELEASE
I, the undersigned, certify that I (or my dependent) have insurance coverage with:_______________ and assign directly to the doctor, 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 payment of benefits. I authorize the use of this signature on all insurance submissions.

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Responsible Party Signature **Relationship to patient** **Date**

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I understand that I am responsible for my account regardless of my insurance. I, also, understand that my insurance is an agreement between me and my insurance company.

I understand that I may be charged 2.0% finance charge per month (20%) annually if my balance goes beyond 90 days.

I give permission for my dentist and clinical team to take necessary radiographs, study models, and photographs to make a complete diagnosis of my dental needs. I, also, give permissions for my dentist and dental team to use my photographs for in-office education.

I consent to the use and disclosure of my protected health information to obtain payment information in connection with my dental claims

____ DATE_________________________________
PATIENT SIGNATURE