Dr. Mary Berk • (636) 528-8911 • www.TroyDentalCare.com

PATIENT REGISTRATION

TODAY'S DATE: _____

EMERGENCY INFORMATION (A RELATIVE NOT LIVING WITH YOU)

NAME _____ RELATION _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE # _____ WORK PHONE # _____ CELL PHONE # _____

How did you hear about our office? _____

Reason for this visit? _____

Is there any other medical or dental information we should know about? _____

FINANCIAL INFORMATION

RETURN CHECK POLICY:

A $25.00 charge in addition to any bank fees, will be charged to your account.

DEFAULT POLICY:

In the case of default of payment, responsible party will pay any legal interest on the balance, together with any collection cost and reasonable Attorney fees incurred to effect collection on this account.

BROKEN APPOINTMENT POLICY:

24 hours notice is required for cancellation of an appointment or it will be considered a broken appointment. Appointment time is reserved exclusively for you, therefore if broken you will be charge an appropriate fee.

OUR OFFICE IS COMMITTED TO MEETING OR EXCEEDING THE STANDARDS OF INFECTION CONTROL MANDATED BY OSHA, THE CDC AND THE ADA.

I understand the the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical or dental status.

Signature _____ Date _____

PLEASE SIGN IN BOTH PLACES

ASSIGNMENT OF BENEFITS

I authorize payment directly to Dr. Mary Berk of the group insurance benefits otherwise payable to me:

SIGNATURE X _____

RELEASE OF INFORMATION

I authorize the release of any information necessary to process my claim.

SIGNATURE X _____

101 WEST COLLEGE, SUITE 3 • TROY, MO 63379