Mark D. Berman, D.D.S. Associates

Patient Registration **44200 Garfield Ste 100 Clinton Township, MI 48038** **586.263.0770**

Name: ______________________ **Birthdate:** __________ **Sex:** **M** **F**

Last *First* *Middle Initial*

Are you: (Please circle one) Minor Single Married

Address: ______________________

Number *Street* *City* *State* *Zip*

Home Ph: __________ **Work Ph:** __________ **Cell Ph:** __________

Do you prefer to receive calls at: Home Work Cell Either

Email address: ______________________

How did you hear about our practice? ______________________

Are other immediate family members patients here? **Yes** **No** **If so, who?** __________

Employed by: ______________________

(Father if child) *Name of company* *Address*

Spouse or parent/guardian's name: ______________________

Spouse Employed by: ______________________

(Mother if child) *Name of company* *Address*

RESPONSIBLE PART **(If patient is over 18, list patient. If patient is under 18, list parent or guardian responsible for payment)**

Person reponsible for this account: ______________________

Relationship to patient: __________ **Birthdate:** __________

Social Security #: __________ **Driver's License #:** __________

Email address: __________ **Employer:** __________

If different than above *If different than above*

Home Ph: __________ **Work Ph:** __________ **Cell Ph:** __________

If different than above *If different than above*

Address: ______________________

Number *Street* *City* *State* *Zip*

If different than above *If different than above*

Insurance Information:

Name of Dental Insurance Co: __________ **Insurance Co Phone #:** __________

Name of Insured: __________ **Birthdate of Insured:** __________

SS # of Insured: __________ **ID # of Insured:** __________ **Group#** __________

Relationship to patient: __________ **Insured's Employer:** __________

Do you have additional dental insurance? ***Yes*** ***No*** ***If yes, please complete the following:***

Name of Dental Insurance Co: __________ **Insurance Co Phone #:** __________

Name of Insured: __________ **Birthdate of Insured:** __________

SS # of Insured: __________ **ID # of Insured:** __________ **Group #** __________

Relationship to patient: __________ **Insured's Employer:** __________

IF YOU ARE A COLLEGE STUDENT: Name of College: __________

City & State: __________ # of Credit Hours: __________ Full-time/Part-time?

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such dental care to third party payors and/or other health practitioners. I authorize and hereby request my insurance company to pay directly to the dentist (or the dental group) insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents.

Signature: ______________________ **Date:** __________

Late Charges: If I do not pay the entire new balance within 25 days of the monthly billing date, a late charge of 1.5% on the balance then unpaid and owed may be assessed each month (if allowed by law). I realize that failure to keep this account current may result in you being unable to provide additional dental services except for dental emergencies or where there is a prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balance.