ADYA SHROTRIYA, DDS

Patient Registration Date: ________________

Patient's Name ________________________________ Preferred Name __________________ DOB ____/____/_______

Mailing Address____ [ ] Male [ ] Female

City ______________________________ State ________________ Zip Code ______________________________

Home Phone ________________________Cell________________________ **May we send you a text? [ ] Yes [ ] No**

Social Security _________________________ Martial Status [ ]Single [ ] Married [ ] Divorced [ ] Widowed

Email Address ____ **May we send you an email? [ ] Yes [ ] No**

Employer Name ____________________________________ Work Phone __________________________ ext________

Spouse's Name ________________________ How did you hear about us? _____________________________________

Person Responsible for this account [ ] Self [ ] Spouse [ ] Parent [ ] Other ____________________________

Name ___________________________________Social Security_____________________ ___DOB _____/____/______

Mailing Address (if different) ____

Home Phone _______________________Cell _____________________ Work_____________________ ext__________

Insurance Information Patient relation to Policy Holder [ ] Self [ ] Spouse [ ] Child [ ] Other _______________

Policy Holder ______________________________ Social Security______________________DOB _____/____/_______

Insurance Company Name ____ Phone __________________________

Group # ______________________________ Member ID __________________________ Payer ID ________________

Insurance Address ____

Employer Name __________________________________ Work Phone ________________________ ext____________

Do you have Secondary Insurance? [ ] Yes [ ] No If yes, please provide additional information in office

Appointment Policy

Your dental appointments are scheduled carefully. Time, trained personnel, and dental equipment are reserved for each appointment. Missed appointments add to the cost of dental care when these reserved facilities are left waiting. We require 24 HOUR advance notice for rescheduling appointments. We reserve the right to charge a fee for a broken or cancelled appointment without 24 HOUR notice.

Insurance and Financial Policy

Total payment is appreciated at the time of service. We accept Cash, Check, Visa, MasterCard, or Discover. Your insurance policy is a contract between you, your employer and the insurance company. In the event we do not receive payment from your insurance company within 90 days of filing a claim with them, the balance will be your responsibility. You are responsible for any services not paid for by your insurance company. Your treatment plan is individually tailored to your dental needs and is not based on your dental insurance benefits and what they may or may not deem as necessary. In order to give you an estimate of cost for your needed dental treatment, we will verify your insurance benefits prior to treatment but they will only give us a basic breakdown of benefits. It is your responsibility to know your contract limitations. It is your responsibility to fully understand the coverage and exceptions of your particular policy.

Consent for Dental Treatment

I hereby give Dr. Adya Shrotriya, DDS my consent for dental treatment. I have read and fully understand the above stated policies and I agree to abide by them. I grant permission to you or your assignee, to telephone me at any phone number above to discuss matters related to this form and to my dental treatment. By signing this form, I further authorize the release of information to my insurance provider.

Patient or Guardian Signature ____**Date**________________________