Welcome to Niceville Family Dental Center
CONFIDENTIAL REGISTRATION INFORMATION

Please Print

Thank you for selecting our dental healthcare team. Please fill out this form completely in ink. If you have any questions or concerns, please do not hesitate to ask for assistance, we will be happy to help.

Date_____

Name_____ SSN_____ Male _____
First MI Last Female_____

Home Address_____ City_____ State_____ Zip_____

Birthdate_____ Home#_____ Work#_____ Cell#_____

Do you prefer to receive calls at: Home____ Cell____ Work____
Would you like to share your e-mail address with us for appointment confirmation only? No____ Yes___
E-Mail address_____

Are you: Single_____ Married_____ Divorced_____ Widowed_____ Separated_____

Your or your Parent/Guardian's employer_____Work#_____

Spouse or Parent/Guardian's name_____Employer_____Work#_____

College Students: College_____City & State_____Full/Part time_____

Person to contact in case of an emergency_____ Phone#_____

Responsible Party

Name of person responsible for this account_____Birthdate_____Relationship_____

SSN_____ Home#_____ Cell#_____Work#_____ Driver's License#_____

Address_____ City_____ State_____Zip_____

Employer_____ Is responsible party currently a patient in our office? Yes_____ No_____

Financial Arrangements

Payment is due in full at each appointment. For your convenience, we offer the following methods of payment:
Cash Personal Check Credit Card (Visa, MasterCard or Discover)

There will be a $30.00 Service Charge for all returned checks.

I will be required to give a 48 Hour notification to cancel appointments. If under 24 hours I will be charged a $50 non-refundable charge per person which will be collected at time of cancellation.
I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents.

Signature of responsible party_____Date_____
****Please complete and sign**

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT

I, _____ BEING OF LEGAL AGE, GIVE NICEVILLE FAMILY DENTAL CENTER AUTHORIZATION TO RELEASE AND DISCUSS MY HEALTH AND DENTAL INFORMATION WITH THE PERSON(S) LISTED BELOW.

POLICY HOLDER_____PHONE #_____

SPOUSE _____PHONE #_____

PARENTS_____PHONE #_____

OTHER_____PHONE#_____

SIGNATURE_____DATE_____