

# WELCOME TO OUR PRACTICE

**WE ARE PLEASED TO WELCOME YOU TO OUR PRACTICE AND LOOK FORWARD TO WORKING WITH YOU IN MAINTAINING YOUR DENTAL HEALTH.**

## PATIENT REGISTRATION

Today's date: \_\_\_\_\_  
Who may we thank for referring you to our office? \_\_\_\_\_  
Patient's Name:  
Last \_\_\_\_\_ First \_\_\_\_\_ Middle Initial \_\_\_\_\_  
Street \_\_\_\_\_ Apt. # \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_  
Social Security # \_\_\_\_\_ Drivers License # \_\_\_\_\_ Sex: M F  
Birthday \_\_\_\_\_ Age \_\_\_\_\_ E-mail \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_ # of yrs employed \_\_\_\_\_

## RESPONSIBLE PARTY

(If different)

Name Last \_\_\_\_\_ First \_\_\_\_\_ Middle Initial \_\_\_\_\_  
Street \_\_\_\_\_ Apt. # \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_  
Social Security# \_\_\_\_\_ Drivers License# \_\_\_\_\_ Sex: M F  
Birthday \_\_\_\_\_ Employer \_\_\_\_\_ E-Mail \_\_\_\_\_

## EMERGENCY INFORMATION

(Not living with you)

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ HmPhone \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

## DENTAL INSURANCE INFORMATION

Insured's Name \_\_\_\_\_ Identification # \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Insurance Company's phone # \_\_\_\_\_  
Insured's Social Security # \_\_\_\_\_ Insured's Birthday \_\_\_\_\_  
Insured's Employer \_\_\_\_\_ Group number \_\_\_\_\_

### Consent

The undersigned hereby authorizes the Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that my dental insurance is a contract between me and the insurance carrier, and not between the insurance carrier and the Doctor and that I am still fully responsible for all dental fees. These fees are due and payable at the time services are rendered unless prior financial arrangements have been made. I also assign all insurance benefits to the Doctor. Any payments received by the Doctor from my insurance coverage will be credited to my account, or refunded to me if I have paid the dental fees incurred. I further understand that a late charge will be added to any overdue balance. I understand that where appropriate, credit, reports may be obtained.

PATIENT SIGNATURE (Parent of Child) \_\_\_\_\_ Date: \_\_\_\_\_

DAVID D. NIX, D.D.S., PA  
3000 North MacArthur Blvd.  
Irving, TX 75062  
(972)659-1050

## INSURANCE CLAIM CONSENT

Yes    No    I will file all insurance claims and paperwork myself (without any  
        assistance from your office.) Total payment is due when service is  
rendered.

Yes    No    I would like this office to perform insurance services to the best of their  
        abilities as a courtesy to me. A portion of my procedure(s) must be  
prepaid (see below). I understand that any balance due on the account  
after 90 days must be paid in full, regardless of insurance still being  
processed. Our office is not responsible for any insurance filing, paper-  
work, radiographs, documentation, etc., after 90 days --- this becomes the  
responsibility of the insured.

Insurance coverage is estimated. I, the patient, am responsible for all amounts not covered by my insurance carrier. If for some reason, the account should become delinquent, (balance greater than 90 days from the date of treatment) I agree to pay for all rebilling charges, interest charged, collection cost, and attorney fees.

Patient's Signature: \_\_\_\_\_

Responsible Party's Signature: \_\_\_\_\_