CODY DENTAL GROUP

Adult Registration
Confidential

Last Name _____ First _____ Middle _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ E-mail _____ Cell Phone _____

Age _____ Date of Birth _____ ○ Male ○ Female

Name of Spouse (if married) _____ Social Security # _____

Name of Employer _____ Phone _____

Employer's Address _____

Length of Employment _____ Occupation _____

Spouse's Employer _____

Employer's Address _____

Length of Employment _____ Occupation _____

Relative (not at same address) _____ Relationship _____

Address _____ City _____ State _____ Zip _____

How did you learn about Cody Dental Group? Cody Patient (name) _____ Family/Friend _____

Website _____ Other (please be specific) _____

Has any member of your immediate family been treated here? ○ Yes ○ No

If yes: Name _____ Relationship _____

Billing Information (If you have dental insurance, please provide that information on the reverse side of this form. The following information must be completed regardless of insurance coverage.)

Responsible Party (If other than self) _____ Social Security # _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

New patient visits require payment on the same day as treatment. Any services billed must be paid upon receipt of statement unless arrangements are made prior to treatment. Credit reports are obtained on all new patients to determine financial eligibility and down payment requirements. A monthly finance charge of 1.5% (18% annually) begins on charges 60 days after billing. Should the account be turned over to a collection agency, I agree to pay all costs of collection including, but not limited to, court costs, agency fees and attorney fees.

Signature _____ **Date** _____

Do you have dental insurance? ○ **Yes** ○ **No** (If yes, please complete the reverse side)

FOR OFFICE USE ONLY Date _____ Doctor _____ Account # _____