PATIENT REGISTRATION

Today's Date:

Patient Name: Sex: M/ F Birthdate: Age:

Home Address: City: State: Zip:

Please Circle One: *Single Married Seperated Widow* Your *Social Sec . #*

Home Ph#: Cell Ph#: E-mail Address:

Your Employer: Work Ph#: How long Employed:

Are you a full time student? ☐Yes ☐ No *If patiet is minor we need: Mother's DOB: Father's DOB:*

Person Responisible for account: Driver's License # Relationship:

Name of Spouse (Parent if Minor): **Spouse's (Parent's) Soc. Sec. #:**

Spouse's (Parent's) Employer: **Work Ph#:** **Cell Ph#:**

EMERGENCY INFORMATION

Name,Address,& phone of a relative not living with you:

Reason for this visit:

How Did you hear about our office?

DENTAL INSURANCE INFORMATION(Primary Carrier)	**If you have secondary insurance**
Insured's Name:	Insured's Name:
Insured's Employer:	Insured's Employer:
Insurance CO:	Insurance CO:
Insurance Co Address:	Insurance Co Address
Phone #: DOB:	Phone#: DOB:
SS#:	SS#:
Group#: Local#:	Group#: Local#:

Thank you for choosing our office as your dental healthcare provider. We are committed to providing you with the highest quality lifetime dental care, so that you may attain optimum oral health. Here at Morgan Family Dentistry we accept a variety of payment options, for your convenience, such as visa/debit, master card, check, cash, and care credit. We understand that financial situations do arise and work hard to find a payment arrangement that works best for you. Care Credit is one payment arrangement offered that allows our patient's to make low monthly payments interest free for up to twelve months. For questions about Care Credit feel free to call (337)534-8888 or go online to carecredit.com.

Do You Have Dental Insurance?

As a service to you, we verify and file with dental insurance via electronic claims. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company. Our office is not a party to that contract. We will cooperate with the regulations and requests of your insurance company that may assist in the claim being paid. We ask that you provide the accurate dental insurance information upon your first visit. If any changes occur with the dental insurance policy, it is the patient's responsibility to provide us with the corrected information. Please keep in mind, our estimates are based on verification of benefits. Your dental provider has reserved the right to deny or downgrade dental services at their discretion. **The patient is responsible for all portions not covered by insurance. If payment is not received from insurance within 90 days, the full balance becomes the patient's responsibilit** y. A $25 dollar fee will be charged for insufficient checks. Dr. Morgan has taken in to consideration that out of pocket expenses are sometimes unexpected and therefore has lowered his overall fees to help compensate. I HAVE READ, UNDERSTAND, AND AGREE TO THE ABOVE TERMS AND CONDITIONS.

Patient Signature: _____ Date: _____