FRESNO DENTAL WORKS **5671 N. Palm Ave. Fresno, CA 93704**

PATIENT REGISTRATION

Please fill in completely

Patient_____ Today's date_____
Last Name First Name MI

Address_____ Date of Birth_____

City_____ State_____ Zip_____ Ph. No._____

Cell Phone number_____ E-mail_____

Employer_____ Bus. Ph._____

Address_____ Soc. Sec. No._____

City_____ State_____ Zip_____ D.L. No._____

Spouse or Guardian Information

Name_____ Relationship to Patient_____

Employer_____ Date of Birth_____

Address_____ Bus. Ph._____

City_____ State_____ Zip_____ Soc.Sec. No._____

OUR PAYMENT POLICY

PAYMENT IS DUE THE DAY OF SERVICE, UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE WITH OUR OFFICE. THANK YOU.

Insurance Information: We will need a copy of your insurance card(s)

Primary Insurance_____ Ins. Phone No._____

Subscriber's Name_____ ID/Policy No._____

Address_____ Group No._____

City_____ State_____ Zip_____

Secondary Insurance_____ Ins. Phone No. _____

Subscriber's Name_____ ID/Policy No._____

Address_____ City_____ State_____ Zip_____ Group No._____

(OVER PLEASE)

Nearest friend or relative not living with you

Name_____Ph. No._____

Address_____City_____State_____Zip_____

Please read and sign:
These statements are true to the best of my knowledge I agree that all accounts in this office must be paid in full on presentation of charges unless prior arrangements have been made. If account is 90 days past due interest charges of 1.5% per month (18% per year) will be added to the outstanding balance each month until the account is paid in full. If prior arrangements are not made, all balances over 6 months old will be sent to collections. If collection is made by attorney or collection agency, I agree to pay all collection costs and reasonable fees of the attorney.

Signed_____**Date**_____

Authorization for Payment of Benefits

I authorize payment of benefits, as determined by the insurance company, directly to: Dennis M. Kalebjian DDS or Roger A. Khater, DDS or Fresno Dental Works.
I also authorize this dental office to furnish my Insurance Company all information which the insurance company may request.
I understand and agree that I will pay for any services not paid for by my insurance provider.

Patient/Responsible party signature_____date_____

APPOINTMENT CANCELLATION POLICY

Every effort will be made to provide dental care timely to your needs and convenient to your daily schedule. In return, we ask that you respect the time you have scheduled with the doctor and his staff by keeping the appointments which you have scheduled and confirmed.

ALL CONFIRMED APPOINTMENTS WILL REQUIRE A 48 HOUR CANCELLATION NOTICE. THIS WILL ENABLE OFFICE STAFF TO PRODUCTIVELY FILL YOUR SPOT WITH A PATIENT IN NEED OF DENTAL CARE. THE FEE FOR MISSING A CONFIRMED DENTAL APPOINTMENT IS $80.00, WHICH MUST BE PAID PRIOR TO RESCHEDULING. ALL APPOINTMENT CANCELLATIONS MUST BE MADE IN DIRECT COMMUNICATION WITH OUR DENTAL OFFICE. TELEPHONE MESSAGE CANCELLATIONS WILL BE ACCEPTABLE ONLY BETWEEN THE HOURS 8 A.M. TO 5 P.M. MONDAY THRU FRIDAY.

IN THE EVENT WE ARE UNABLE TO REACH YOU FOR CONFIRMATION OF YOUR DENTAL APPOINTMENT, WE RESERVE THE RIGHT TO CANCEL YOUR APPOINTMENT IN FAVOR OF ANOTHER PATIENT IN OUR PRACTICE WHO MAY BE IN NEED OF IMMEDIATE CARE.

Waiver on the above policy will be given consideration when appropriate.

I understand and accept the above appointment cancellation policy.

Signed_____**Date**_____

Thank you