Joseph C. Ardizzone, D.D.S.
30317 16th Avenue So
Federal Way, WA 98003

REGISTRATION FORM

Please Print

Patient'sName_______________________________Birthdate_____________ Single ____ Married ____ Divorced _____ Separated _____ Widowed ______
Address________________________________ City ________Zip________
Social Security Number _____-_____-______ Driver's License #__________
Employed by ___________________________ Present Position__________
Employer's Address _____________________ City ____________Zip______
Home Ph # _____________ Cell Ph #____________ Business Ph #__________
Email Address _________________________
Dental Insurance Co ____________________ Group/Policy #_____________
Is your spouse covered by your insurance plan? Yes / No (circle one)

Spouse's Name ________________________________ Birthdate __________
Social Security Number _____-_____-______ Driver's License # _________
Employed by ___________________________ Present Position __________
Employer's Address _____________________ City ___________ ZIP _____
Home Ph# _____________ Cell Ph #____________ Business Ph # __________
Email Address __________________________
Dental Insurance Co _____________________ Group/Policy #_________
Are you (patient) covered by your spouse's plan? Yes / No (circle one)

Person responsible for this account: __ Patient ___ Spouse ___ Other
Address (if different than above) ___________________________
City _______________________ State ______ ZIP _______
Home Phone ________________ Business Phone ___________

Whom may we thank for referring you to our office? ____________________________

All professional services are charged to the patient. Necessary forms will be completed to expedite insurance carrier payments. The patient is responsible for all fees, regardless of insurance coverage.
I hereby authorize the release of any information including the diagnosis and the records of any treatments or examinations rendered to my insurance company or companies.

I hereby authorize payment directly to Dr. Joseph C. Ardizzone of the insurance benefits otherwise payable to me. I understand I am financially responsible for any charges not paid by my insurance company(s).

Patient's Signature ___________________________________ Date________________

NOTICE OF PRIVACY PRACTICES—ACKNOWLEDGEMENT

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting Teresa Murray, Office Manager.

Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

_______________________________________ ______________

Patient or legally authorized individual signature Date

____ _________________

Printed name if signed on behalf of the patient Relationship
(parent, legal guardian, personal representative)

This form will be retained in your medical record.

DR. JOSEPH C. ARDIZZONE
Family Dentistry

OFFICE FINANCIAL POLICY

This letter is to acquaint you with our office financial policy and to avoid any possible misunderstandings.

1. Our responsibility is only to **you**, the patient. We practice preventive dentistry and stress the importance of regular care to help you in your goal to achieve and maintain excellent dental health.

2. Although we honor dental insurance the **payment for services is the personal responsibility of the patient**, not the insurance company. We approximate the amount your insurance company will pay. We will expect a payment from you at each visit ranging between 10%-60% of the services rendered, depending on coverage for that particular service.

3. **Payment is due at the time services are rendered**. We accept cash, personal checks, Debit and honor Visa and Mastercard as forms of payment.

4. If you have dental insurance, it is your responsibility to bring your information in to us. We are happy to submit a statement of services to your insurance carrier for each visit. **All balances are due and payable in thirty (30) days by the patient, unless a written payment schedule is approved by the office.**

5. **Should a balance accrue on your account, it is due upon receipt of a statement**, unless a written payment schedule is approved by the office. Balances outstanding and greater than 90 days accrue interest at 1.20% per month. If you have a credit balance on your account after all insurance payments are in, we will leave the credit on your account to be used toward future services or gladly refund the difference to you.

6. **All patients are seen by appointment only**. We try to see our patients as promptly as possible. However, there are times when emergencies arise and we are unavoidably delayed. We hope you understand during these circumstances.

7. We ask that our patients please give **24 hours notice** when rescheduling an appointment. Failure to do so may result in a **broken appointment charge of $50.00 per half hour** that is scheduled.

Our goal is to make your dental appointments as comfortable and pleasant as possible and to keep you informed of our financial policies and office procedures. If you have any questions or suggestions please let us know.

"I have read and understand my responsibilities listed in the above policy. In addition, I have received a copy of this letter."

Signature ___________________________ Date _________________________

DR. JOSEPH ARDIZZONE * 30317 16TH AVE SO * FEDERAL WAY, WA 98003 * PHONE (253) 839-7270