• New Patient Registration

Last Name ______________________ First Name ______________________ Date of Birth DAY MO YEAR

Address ____ Apt. ____________

City ______________________________ Province __________ Postal Code ____________

Home Phone ____ – ____ – ____ Business ____ – ____ – ____ Cell ____ – ____ – ____

Email Address ______________________ Sex __________ Marital Status ____________

Occupation ______________________ Employer ______________________

Emergency Contact ______________________ Relationship __________ Phone ____ – ____ – ____

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

Financial Policy

City South Dental requires payment in full for services rendered on the day of treatment.
For your convenience we accept Debit, Visa and Mastercard.

For patients with dental insurance:

We also accept direct payment from your dental insurance company. In order to provide exceptional service and to deliver quality care to our patients, we will submit a predetermination or estimate to your insurance carrier prior to commencing any major treatment or as requested by you.

Please read carefully before selecting your preferred payment option.

☐ **Payment Option 1: Assignment of insurance benefits directly to City South Dental**

I authorize my insurance carrier to pay City South Dental directly. I understand that my dental insurance is a contract between myself and my insurance carrier. It is, therefore, my responsibility to understand what my insurance coverage entails. I understand that I am responsible for any deductibles and/or differences in fees not covered by my insurance plan. I am providing my credit card information to be kept on file for this reason and to clear any balance on my account within 60 days.

Credit card type: ☐ Visa ☐ Mastercard

Credit card number ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐

Name on card ______________________________ Expiry date DAY MO CVV ☐☐☐

Signature ______________________________

☐ **Payment Option 2: Payment by patient on day of service**

I choose not to leave my credit card information on file. Therefore, I agree to pay for the services rendered on the day of treatment. City South Dental will aid in the submission of insurance claims wherever possible. The insurance company will reimburse me directly.

Appointment Policy

When you make an appointment with our office, we consider this a mutual commitment and reserve appropriate facilities and staff exclusively for you. If you find that you must change your appointment, we require a minimum of 2 business days' notice. If appointments are missed/broken without advance notification, a fee will be applied to your account.

General Consent to Treatment

I agree and consent to a dental examination at City South Dental. I understand that additional diagnostic procedures and dental treatments may be recommended and will be discussed with me prior to being done. I also acknowledge that there are no guarantees, expressed or implied, as to the results of any procedures or dental treatments performed.

Release of Information

I authorize City South Dental to release any information regarding my dental/medical history, diagnosis or treatment to other health professionals as necessary.

Communication

I authorize City South Dental to communicate with me via text, email and telephone.

I understand and will comply with the policies outlined above.

Signature of patient, parent or guardian ______________________________ Date DAY MO YEAR