Preeti Chitgopekar DDS INC
3130 Crow Canyon Place #195
San Ramon
(925) 838 - 8166

DENTAL NEW ADULT PATIENT REGISTRATION

Date:_____

Patient's Name: _____

Home Address: _____

Birthdate: _____ Social Security: _____ Driver's License: _____

Email Address: _____Mobile Phone: _____

Patient's Employer: _____ Phone Num: _____

Emergency contact name and phone: _____ Phone Num: _____

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

DENTAL INSURANCE INFORMATION OF THE RESPONSIBLE POLICY HOLDER

PRIMARY INSURANCE POLICY

Name of Policy Holder: _____

Relationship to Patient: _____ Is the Policy Holder responsible for the Patient's account? _____

Policy Holder's Birthdate: _____ Social Security No: _____ Driver's Lic No: _____

Dental Insurance Company Name: _____ Phone No:_____

Policy Holder's Insurance ID No: _____ Policy Holder's Insurance Group No: _____

Policy Holder's Employer: _____ Phone Num: _____

SECONDARY INSURANCE POLICY

Name of Policy Holder: _____

Relationship to Patient: _____ Is the Policy Holder responsible for the Patient's account? _____

Policy Holder's Birthdate: _____ Social Security No: _____ Driver's Lic No: _____

Dental Insurance Company Name: _____ Phone No:_____

Policy Holder's Insurance ID No: _____ Policy Holder's Insurance Group No: _____

Policy Holder's Employer: _____ Phone Num: _____

Patient's Initials: _____

TREATING PHYSICIAN AND SPECIALISTS INFORMATION (*as applicable*)

Physician: _____ Phone: _____

Cardiologist: _____ Phone: _____

Endocrinologist: _____ Phone: _____

ObGyn: _____ Phone: _____

Therapist: _____ Phone: _____

Please be aware that we collect estimated insurance portions at each visit. Your insurance policy is a contract between you and your insurance company. You are responsible for any unpaid balances, regardless of the original estimate of insurance benefit. As a courtesy to you we will file your claims with your insurance company. Insurance payments are normally received within 30 to 45 days. Any unpaid balances after 60 days are your responsibility and are due at that time. All deductibles and copayments are due at the time of service. A completed claim form or copy of your insurance card will need to be kept on file in our office. We try to answer any questions you may have about your insurance company, however you may need to contact your insurance company for additional information. If your insurance changes, it is your responsibility to provide updated information to us.

Assignment of Benefit: Please read and sign to have our office file your insurance: I authorize the release of information and understand that I am responsible for all costs of dental treatment. I hereby authorize payment directly to Preeti Chitgopekar DDS, INC of the insurance benefits otherwise payable to me.

X Signature of Patient: _____ Date: _____

FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT:

I authorize treatment of the person named above and agree to pay all fees and charges for such treatment. I agree to pay all charges for and by members of my family shown by statements, promptly upon presentation thereof. Charges shown by statements are agreed to be correct and reasonable unless protested in writing within 30 days of billing date. In event legal action should become necessary to collect an unpaid balance due for medical services rendered to my family or me I/we agree to pay reasonable attorney's fees or other such costs as the Court determines proper. It is agreed that all payments will not be delayed or withheld because of any insurance coverage or the pendency of claims thereon, and all proceeds of insurance are assigned to this office where applicable, but without their assuming responsibility for the collection thereof. (A copy of this assignment is as valid as the original.) NOTICE: Do not sign this agreement before you read and agree to the conditions set forth. You are entitled to a copy of this agreement at the time you sign. Keep it to protect your legal rights.

X Signature of Patient : _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (HIPAA)

***** YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT *****

I have received a copy of this office's Notice of Privacy Practices and consent to the healthcare operations it describes.

X Signature of Patient: _____ Date: _____