John R. Ludwig DDS

LIFE-CENTERED DENTISTRY

(616) 453-3111 | 2030 Leonard St. NW Grand Rapids, MI 49504

PLEASE PRESENT PHOTO ID

Patient Registration

Name _____ Preferred Name_____

BIRTHDATE_____/_____/_____ SS#_____MALE/FEMALE SINGLE/MARRIED/SEPARATED/DIVORCED/WIDOWED

ADDRESS_____CITY/STATE/ZIPCODE_____

HOME PHONE_____CELL PHONE _____WORK PHONE_____

E-MAIL ADDRESS _____

CIRCLE APPOINTMENT REMINDER PREFERENCE: PHONE CALL / TEXT / E-MAIL

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

IF UNDER 18: PARENT/GUARDIAN RESPONSIBLE FOR PAYMENT_____SS#_____

PLEASE INCLUDE NAME, ADDRESS, PHONE (IF DIFFERENT THAN PATIENT)_____

_____

DENTAL INSURANCE INFORMATION—PLEASE PRESENT CARD UPON ARRIVAL

Primary Dental Insurance

NAME OF SUBSCRIBER_____ RELATIONSHIP TO PATIENT_____

BIRTHDATE____/_____/_____SS#_____EMPLOYER_____

INSURANCE COMPANY_____PHONE NUMBER_____

INSURANCE COMPANY ADDRESS_____

Secondary Dental Insurance

NAME OF SUBSCRIBER_____RELATIONSHIP TO PATIENT_____

BIRTHDATE____/_____/_____SS#_____EMPLOYER_____

INSURANCE COMPANY_____PHONE NUMBER_____

INSURANCE COMPANY ADDRESS_____

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WRITTEN OFFICE POLICY

PAYMENT IS DUE AT TIME OF SERVICE UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE. IF YOU HAVE DENTAL INSURANCE, WE WILL SUBMIT YOUR CLAIM FOR YOU. WE DO ACCEPT CASH, PERSONAL CHECK, DISCOVER, MASTERCARD, VISA OR CARECREDIT. A 5% COURTESY WILL BE EXTENDED FOR CASH OR CHECK CO-PAYS PAID IN FULL ON DAY OF SERVICE.

IF YOU DO NOT PAY YOUR ENTIRE ACCOUNT BALANCE WITHIN 60 DAYS OF SERVICES BEING RENDERED, A $10 BILLING CHARGE WILL BE ADDED TO YOUR ACCOUNT. FAILURE TO KEEP YOUR ACCOUNT CURRENT MAY RESULT IN DISMISSAL AS A PATIENT, WITH ONLY EMERGENCY TREATMENT BEING PROVIDED BY THE DENTIST AND PAYMENT REQUIRED AT TIME OF SERVICE. ANY ACCOUNT OVER 90 DAYS OUTSTANDING WILL BE SENT TO A COLLECTION AGENCY OR SMALL CLAIMS COURT AND ANY COLLECTION FEES MUST BE PAID PRIOR TO ANY ADDITIONAL TREATMENT.

WITH THE EXCEPTION OF ILLNESS AND EMERGENCIES, A $50 FEE WILL BE CHARGED FOR MISSED APPOINTMENTS OR CANCELLATIONS WITHOUT A 24 HOUR NOTICE. WE OFFER A FEW DIFFERENT OPTIONS FOR APPOINTMENT REMINDERS.

PLEASE SIGN BELOW INDICATING THAT YOU HAVE READ THE INFORMATION ABOVE AND AGREE TO THE TERMS STATED.

_____/_____/_____
SIGNATURE OF PATIENT/PARENT/GUARDIAN DATE

PLEASE READ AND SIGN 3 TIMES BELOW RELATING TO OUR HIPAA PRIVACY INFORMATION

ACKNOWLEDGEMENT OF PRIVACY/SECURITY RULE
I ACKNOWLEDGE THAT I HAVE BEEN PRESENTED WITH A COPY OF THE HIPAA PRIVACY PRACTICE/SECURITY RULE. I UNDERSTAND THAT MY PROTECTED HEALTH INFORMATION WILL NOT BE SOLD FOR MARKETING OR RESEARCH PURPOSES AND I HAVE THE RIGHT TO OBTAIN A COPY OF MY PROTECTED HEALTH INFORMATION.

1)_____/_____/_____
SIGNATURE OF PATIENT/PARENT (IF PATIENT IS A MINOR, PLEASE PRINT CHILD'S NAME NEXT TO SIGNATURE)

AUTHORIZATION AND RELEASE
I AUTHORIZE DR. LUDWIG OR HIS STAFF TO RELEASE INFORMATION, WITH MY CONSENT, INCLUDING THE DIAGNOSIS AND/OR RECORDS OF ANY TREATMENT OR EXAMINATION RENDERED TO ME OR MY CHILD, TO DENTAL OR MEDICAL INSURANCE COMPANIES OR OTHER DENTAL HEALTHCARE PROVIDERS. I AUTHORIZE AND REQUEST MY INSURANCE COMPANY TO PAY DIRECTLY TO THE DENTIST BENEFITS OTHERWISE PAYABLE TO ME. I UNDERSTAND THAT MY DENTAL INSURANCE CARRIER MAY PAY LESS THAN THE ACTUAL BILL FOR MY SERVICES. I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON MY BEHALF OR MY DEPENDENTS.

2)_____/_____/_____
SIGNATURE OF PATIENT/PARENT (IF PATIENT IS A MINOR, PLEASE PRINT CHILD'S NAME NEXT TO SIGNATURE)

CONSENT TO TREAT
I AUTHORIZE DENTAL TREATMENT DISCUSSED WITH ME TO BE PERFORMED BY DR. LUDWIG OR HIS STAFF.

3)_____/_____/_____
SIGNATURE OF PATIENT/PARENT (IF PATIENT IS A MINOR, PLEASE PRINT CHILD'S NAME NEXT TO SIGNATURE)

IF NECESSARY, I AUTHORIZE THE **SHARING OF MY INFORMATION** WITH:

_____ _____
NAME RELATIONSHIP PHONE PATIENT INITIALS