Marina Bay DENTAL ASSOCIATES

308 Victory Road
Quincy, MA 02171
P: 617-479-8080 F: 617-479-8189

PATIENT INFORMATION

Date of Birth _____ ☐Male ☐Female ☐ Child*

Patients Name _____ Preferred Nickname: _____
Last First Initial

* Parents Name (If patient is child) _____
Last First Initial

Patient/Parent Social Security Number _____

HOME ADDRESS

Street _____

City/State/ Zip _____

CONSENT TO CONTACT:

Please check each method you wish to be contacted by regarding appointments, treatment, insurance, and your account information. I understand that I can withdraw my consent at any time. **Initial** _____

☐Home # _____

☐Business # _____

☐Cellular # _____

☐Text # _____

☐Email _____

DENTAL INSURANCE COVERAGE ☐Y ☐N

Insured Name _____

Insured Date of Birth _____

Insured Social Security Number _____

Insured Employer _____

Name of Insurance Company _____

Subscriber ID number _____

Group Number _____

Insurance Telephone _____

EMERGENCY CONTACT

Name _____ Phone _____

REFERRAL

Whom may we thank for this referral? _____

**CANCELATION AND FINANCIAL POLICY **

Initial_____I understand that a fee of $50 will incur for a canceled or missed appointment without a two-business day notice. We are dedicated to assisting you achieve and maintain your oral health. As a courtesy to our patients who have dental insurance, we will be happy to file your claims. It is your responsibility to know the rules and benefits of your insurance policy, and to inform us if your insurance information has changed. Your co-payment is due in full on the day of service. Please be aware that estimated co-payments given by staff members are to be considered as such, and that your insurance company may consider some or possibly all treatment as non-covered services. A finance charge of 1.5% will be added to accounts that have balances over than 90 days.

By signing this policy, you agree to be responsible for all fees not covered by your insurance company.

Name: _____ Signature: _____ Date: _____

REGISTRATION * FINANCIAL POLICY