Dr. E. Charles Beliveau, D.D.S.

Patient Registration

We appreciate your choosing us as your dental care provider. Thank you for taking the time to read and complete the attached paperwork. Please let us know if you have any questions or concerns.

PATIENT INFORMATION

Patient's Name: (Last)________________________ (First)________________________ (MI): __________
Date of Birth: ______________ Social Security #: ______________ e-mail Address: ______________
Address: ____
Telephone #: __________ Work Phone#: ______________ Cell Phone #: ______________
If patient is a child, please give parent/guardian's name: ______________________
Emergency Contact: ______________________ Telephone #: ______________
What are your dental concerns today? ______________________
Who may we thank for your referral? ______________________

DENTAL INSURANCE INFORMATION

Dental Insurance Company: ______________________
Dental Insurance Policy #: ______________ Group #______________
Dental Insurance Company Address: ______________________

Subscriber's Full Name: (last)________________________ (First)________________________ (MI)__________
Subscriber's Date of Birth: ______________ Subscriber's Social Security #: ______________
Patient's Relationship to Subscriber: (check one) ____Self____ Spouse____Child____Step-Child ____ Other
Subscriber's Address: ______________________
Subscriber's Employer: ______________________
Subscriber's Employer's Address: ______________________

FINANCIAL POLICY

Please read and sign

Full payment is due at time of service, unless other financial arrangements have been made. We accept cash, checks, debit cards and most major credit cards.

- We cannot bill your insurance company unless you provide all insurance information. Filing claims with your insurance company is a courtesy extended to our patients. Your insurance policy is a contract between you and your insurance company. We may accept assignment of insurance benefits. The balance is your responsibility, whether your insurance company pays or not. Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for this region. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. Balances over 90 days are subject to finance charges.

- Adult patients are responsible for full payment at time of services unless other financial arrangements have been made. The accompanying adult and the parents (or) legal guardians are responsible for payment for the minor unless financial arrangements have been made. Balances over 90 days are subject to finance charges.

- Time is reserved according to your specific treatment needs. Please help us serve you better by keeping scheduled appointments.

This is to certify that I have read a copy of Dr. E. Charles Beliveau's Notice of Privacy Practices (HIPPA) and financial Policies.

______________________________ Signature of Patient or Responsible Party

______________ Date

PATIENT AUTHORIZATION FOR RELEASE OF RECORDS

I,______________________________ authorize ______________________to release
(patient, parent or guardian)

records, relevant to dental treatment, or copies of such for the family members listed below:

Name: ____________________________________ Relationship: _______________
____________________________________ _______________
____________________________________ _______________
____________________________________ _______________
____________________________________ _______________

Office Name: Dr. E. Charles Beliveau D.D.S., PLLC

Dentist: Dr. E. Charles Beliveau D.S.S., PLLC

Address: 987 Osgood Street
(Street)

City/State/Zip Code: North Andover, MA 01845
(City/State/Zip Code)

E-Mail: doctor@beliveaudental.com

Signature:___________________________ S.S.#:__________________Date: _______
(patient, parent,guardian)

Witnessed by________________________________