Welcome to the office of Roy C. Blake III, DDS, MSD

NEW PATIENT REGISTRATION

Patient Information

First Name: _____ Last Name: _____ Middle Initial: _____

Preferred Name: _____ Are you the responsible party? Yes No

Date of Birth (MM/DD/YY): _____/_____/_____ Age: _____ Gender: Male Female

Social Security Number: _____ - ____ - _____ Driver's License #: _____

Mailing Address: _____ Unit/Apt: _____

City: _____ State: _____ Zip Code: _____

Phone Numbers: Home: (_____) _____ - _____ Cell: (_____) _____ - _____ Work: (_____) _____ - _____

Email address: _____

How did you hear about Dr. Blake? _____

Payments and Appointments – Please Initial and Sign

_____ PAYMENT IS EXPECTED AT THE TIME OF SERVICE. Unless special arrangements have been made in advance of your appointment, payment is due when services are rendered.

_____ MISSED APPOINTMENTS AND APPOINTMENTS CANCELLED WITH LESS THAN 24 HRS NOTICE ARE SUBJECT TO A CANCELLATION FEE. Dr. Blake treats patients one at a time. We do not double book. A broken appointment affects many people. If you are unable to keep a scheduled appointment, please let us know as soon as possible.

_____ AS A COURTESY, WE WILL MAIL A DENTAL INSURANCE CLAIM ON YOUR BEHALF FOR YOUR REIMBURSEMENT. If you have a PPO dental insurance plan, can see a dentist out of the network, and want us to submit your claim, please provide a copy of your insurance card. Blake is not contracted with any insurance plans, and we are not responsible for verifying insurance coverage. Even if you have dental coverage, payment is still due at the time of service. Please note that we are unable to accept insurance reimbursement checks as payment for treatment fees.

_____ WE ACCEPT CARECREDIT AS PAYMENT. We accept the 6 month 0.0% interest option, as well as the 2, 3, 4, and 5 year long-term interest options. Please ask a staff member for more information.

I understand and agree to the terms outlined above.

Signature: _____ Date: _____

Informed Consent

I, the patient, authorize Dr. Blake and his staff to perform any necessary dental services during diagnosis and treatment with my informed consent.

Signature: _____ Date: _____