SERGEANT BLUFF SMILES
DR. LAURA GIESE, D.D.S.

PATIENT REGISTRATION

Please complete all questions

Patient Information

Name _____

Address _____ City, State, Zip _____

Home Phone _____ Cell Phone _____

Personal Email _____

Birth date _____ Social Security # _____

Employer _____ Job Title _____

What is your preference for contact: Email___Text___Phone___

Responsible Person if other than patient

Name _____

Address _____ City, State, Zip _____

Home phone _____ Cell Phone _____

Personal Email _____

Birth date _____ Social Security # _____

Primary Insurance Information

Name of Insured _____ Insured's Social Security # _____

Birth date of Insured _____ Relationship to Insured Self___Spouse___Child___Other___

Employer _____ Insurance Company _____

SERGEANT BLUFF SMILES
DR. LAURA GIESE, D.D.S.

How did you hear about us? _____

Is there anyone we can thank for referring you? _____

We want to THANK YOU for choosing us to be your Dental Health Provider.

The following is our Financial Policy.
We ask that all patients read and sign prior to being seen by the doctor OR hygienist.

- Your insurance is a contract between you and your insurance company. We will be happy to file your insurance claim for you. Your insurance payments should be paid to us.
- Your insurance company will only pay for services that are covered by your policy. Your policy may deny payment for some or all services. Please check your benefits. We would be happy to assist you with this.
- We are a provider for many insurance companies. Your estimated share is due at the time of service. If we don't participate with an insurance company, your out-of-pocket expenses may be more.
- If there is a remaining balance due after your insurance has paid, we expect the balance to be paid in full within 30 days. If payment is unable to be made, please consult with our front desk coordinator for alternate payment options.

By signing below, you acknowledge that you have been informed that your insurance may deny payment for services rendered. If your insurance denies payment, or only pays a portion of the charges, you agree to be personally and fully responsible for payment in full.

If entire remaining balance is not paid in full within 30 days of insurance payment, a late fee of 1.5% will be applied to the balance each month that it is not paid.

Signature of Patient, Parent or Guardian: _____ Date _____

Secondary Insurance Information

Name of Insured _____ Insured's Social Security # _____

Birth date of Insured _____ Relationship to Insured Self___Spouse___Child___Other___

Employer _____ Insurance Company _____