

PATIENT REGISTRATION

ID: _____ Chart ID: _____

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

Patient Is: Policy Holder Preferred Name: _____

Responsible Party

Responsible Party (if someone other than the patient)

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

Address: _____ Address 2: _____

City, State, Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Birth Date: _____ Soc Sec: _____ Drivers Lic: _____

Responsible Party is also a Policy Holder for Patient Primary Insurance Policy Holder Secondary Insurance Policy Holder

Patient Information

Address: _____ Address 2: _____

City: _____ State / Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Sex: Male Female Marital Status: Married Single Divorced Separated Widowed

Birth Date: _____ Age: _____ Soc. Sec: _____ Drivers Lic: _____

E-mail: _____ I would like to receive correspondences via e-mail.

Section 2

Section 3

Employment Status: Full Time Part Time Retired

Additional Comments:

Student Status: Full Time Part Time

Medicaid ID: _____ Pref. Dentist: _____

Employer ID: _____ Pref. Pharmacy: _____

Carrier ID: _____ Pref. Hyg.: _____

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: Self Spouse Child Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: _____ City,State,Zip: _____

Rem. Benefits: _____ .00 Rem. Deduct: _____ .00

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: Self Spouse Child Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: _____ City,State,Zip: _____

Rem. Benefits: _____ .00 Rem. Deduct: _____ .00



MHC Healthcare

quality healthcare with a heart

13644 N Sandario Road* Marana, AZ*85653

Phone: 520-616-6200

BILLING INFORMATION

We would like to make our billing and payment process easy to understand. The MHC billing department is here to help you with any questions you have regarding statements, payment plans, or insurance payments. You may contact the MHC billing office Monday-Friday from 8-4 at 520-818-3616. Thank you for choosing Marana Health Center for your Dental Services.

Our Relationship with your Insurance Carrier

As a courtesy to you, we file your primary and secondary insurance claims. Ultimately, YOU are responsible for all charges.

Co-Payments

Co-payments are due at the time of service and should be paid at each office visit. Services may be delayed or rescheduled, if payment is not received.

Collections

If payment on an account has not been received in over 90 days, the account will be sent to collections. Collection agencies will add additional fees and may report your payment history to a credit reporting agency (Transworld, Equifax, etc.).

Returned Checks

Returned checks will be charged fees based on Federal, State, and Local laws. Payments on a returned check must be settled with cash, money order or cashiers checks. Returned checks are subject our collection policy.

Appointments

If you are not able to keep your scheduled appointment, please notify our office at least 48 hours in advance. The Dental Department hours of operation are 7:30-5. You can reach us at 520-616-6200.

I _____ understand and accept the conditions and policies stated above.

Signature _____ Date _____

Consent form for Dental Treatment and X-rays

Patient Name (please print) _____

Date of Birth _____ Phone Number _____ - _____

Name of Person completing this form _____

Address _____ City _____ State _____ Zip _____

Indicate Relationship to Patient I am patient Parent Grandparent
 Legal Guardian Parent Rep. Other _____

Legal Guardians are required to present legal documentation demonstrating authorization to make medical/dental decisions for a minor or dependant or incompetent adult.

Grandparents, Parent Representatives and others are required to have written notarized authorization to approve treatment for a minor child. We also require a phone number to reach the parent. The custodial parent must sign and date the letter for the date of service and must include the name of the person accompanying the minor. A photocopy of an acceptable signature bearing ID (Drivers License BTC) of the parent and the letter containing the appropriate information may be used.

FEMALE Patient: I am pregnant I am NOT pregnant There is a possibility of Pregnancy.

I consent to diagnose x-rays, examination, treatment planning, as well as all necessary dental treatment to correct the dental conditions diagnosed by the dentist. I also consent to the use of dental anesthetics and any further diagnostic x-rays that may be necessary to successfully complete my dental treatment.

I acknowledge that this consent is given only after the treatment plan options with associated risks and benefits have been explained to me by the dentist or his/her staff. This consent shall remain in effect for the duration of the treatment plan dated ___/___/___ unless the patient, parent or legal guardian revokes consent writing to dentist.

I acknowledge my responsibility to pay for the treatment according to the established fees. Furthermore, I authorize any insurance payment for services to be paid directly to Marana Health Center. I authorize the release of any medical/dental information to my insurance company or referral providers to secure services of payment.

Signature of Patient, Parent, or Legal Guardian

Date



Marana Health Center

PRIVACY NOTICE

Patient Name _____
(PRINT NAME)

DOB: _____ M. R. #: _____

Acknowledgement of Receipt of Notice of Privacy Practices

Attached is a copy of the Notice of Privacy Practices for the Marana Health Center dated 4/14/03. This notice provides information about your rights with regards to your health care information and how the Marana Health Center will use and disclose your health care information.

Your signature on this form acknowledges that you have received a copy of Marana Health Center's Notice of Privacy Practices.

Patient _____

OR Patient Representative _____

Relationship to Patient _____

Date _____

Nombre del paciente _____
(LETRAS DE MOLDE)

Fecha de nacimiento _____

Exp. M.R.#: _____

Acuse de recibo del aviso de privacidad

Se adjunta una copia del Aviso de Privacidad de Marana Health Center de fecha 14 de abril de 2003. Este aviso le informa sobre sus derechos con respecto a su información médica y cómo Marana Health Center podrá usar y revelar información sobre su salud.

Al firmar este documento, usted acusa recibo de la copia del Aviso de Privacidad de Marana Health Center.

Paciente _____

o representante del paciente _____

relation al paciente _____

Fecha _____