Paul Coggins
DDS, MPH

welcome

www.paulcogginsdds.com

Your name _____
Last First Initial

Date _____ Date of birth _____ Gender _____

Spouse/parent's name _____ Whom may we thank for your referral? _____

Address _____ City _____ State ____ Zip _____

Phone (mobile) _____ Other _____ Fax _____ Business _____

eMail _____

Who is responsible for this account? _____ Responsible Party SS# _____

In case of emergency, please notify _____ Emergency Phone(s) _____

dental insurance 1st coverage

Employee Name _____ Date of Birth _____
Employer Name _____
Insurance Company _____
Address _____
City _____ State _____ Zip _____
Telephone _____
Program or Policy No. _____
Social Security No. of Policy Holder _____
Group # _____

dental insurance 2nd coverage

Employee Name _____ Date of Birth _____
Employer Name _____
Insurance Company _____
Address _____
City _____ State _____ Zip _____
Telephone _____
Program or Policy No. _____
Social Security No. of Policy Holder _____
Group # _____

Financial Agreement:

I understand that my dental care insurance carrier (if I have dental insurance), may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts. By signing this contract, I agree to be responsible for payment of services. I understand that if my account is not paid in full in 30 days after treatment, I agree to pay interest charges of 1.3% per month (APR 16%) unless other arrangements are made prior to services rendered.

Release:

I authorize Dr. Paul Coggins to perform diagnostic procedures and treatments as necessary for proper dental care.

I authorize release of any information concerning my (or my child's) health care, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits and/or other dentists.

Signature of responsible party _____ Date _____

REGISTRATION