JAMES L. MUNCY, D.D.S., P.C.
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2817 NORTH PARHAM ROAD
RICHMOND, VA 23294

PATIENT REGISTRATION

Name_____ Birthdate____/____/____ SS#_____
Address_____ City_____ State_____ Zip_____
Home phone_____ Work phone_____ Cell phone_____
E-mail_____
Occupation_____ Employer/School_____
Sex: Male Female Marital status: Single Married Divorced Separated Widow
Name(s) of other family member(s) seen in this practice_____
How did you hear about our practice?_____
Emergency contact_____ Tel #_____ Relation_____

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT

Name_____ Birthdate____/____/____ SS#_____
Address (if different from patient's)_____
City_____ State_____ Zip_____
Relationship to patient: Self Spouse Parent Other_____
Employer_____ Business phone_____
Spouse's name_____ Birthdate____/____/____ SS#_____
Employer_____ Business phone_____

DENTAL INSURANCE INFORMATION

Insurance company name_____ Phone#_____
Policyholder_____ Birthdate____/____/____ SS#_____
Group#_____ Patient relationship to the insured: Self Spouse Child Other_____

SECONDARY COVERAGE

Insurance company name_____ Phone#_____
Policyholder_____ Birthdate____/____/____ SS#_____
Group#_____ Patient relationship to the insured: Self Spouse Child Other_____

Please present your insurance card(s) and driver's license for duplication.

1) I understand that all responsibility for payment of dental services provided in this office for myself or my dependents is mine, due and payable at the time the services are rendered, unless other arrangements have been made. If I have dental insurance, this would mean deductible and co-payments. In the event payments are not received by the agreed upon dates, I understand that a 1½% finance charge may be added to the account with a minimum of $1.00.
<We accept cash, check, VISA or MasterCard>
2) In the event my account is forwarded to an attorney or to a collections agency for collection, I agree to pay all collection fees and court costs, including attorney's fees or collection agency fees in the amount of thirty-three and one-third percent (33 1/3%) of the total indebtedness then due.
3) Unless cancelled **at least 24 hours in advance,** there may be a charge for missed appointments.
<Please help us serve you better by keeping scheduled appointments>
4) The information on this form is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form. I understand that my signature will be used as a "Signature on file" for insurance processing. A photocopy of this contract shall be considered as valid as the original.

Signature_____ Date_____
Patient or Parent/Legal guardian (if minor)