QDP PATIENT REGISTRATION FORM

LAST NAME: _____ FIRST NAME: _____ MI: _____

ADDRESS: _____ CITY, STATE, ZIP: _____

PHONE: (____) _____-_____ SECONDARY PHONE: (____) _____-_____

DOB: _____/_____/_____ EMPLOYER: _____

BILLING

PERSON RESPONSIBLE FOR BILL (*ONLY COMPLETE IF DIFFERENT FROM PATIENT*)

RELATIONSHIP TO PATIENT: (CHECK ONE): ( ) SELF ( ) SPOUSE ( ) PARENT

NAME: _____ DOB: _____/_____/_____

SOCIAL SECURITY #: _____ - _____ - _____ ADDRESS: _____

PHONE: (____) _____-_____

LIST ANY DEPENDANTS:

NAME	DOB	RELATIONSHIP

TOTAL DUE $_____

METHOD OF PAYMENT (CHECK ONE): ( ) CASH ( ) CHECK ( ) CREDIT/DEBIT CARD ( ) OTHER

PLEASE READ DISCLAIMER AND SIGN BELOW:

Using Quality Dental Plan (QDP), in our office offers significant savings to our patients on dental services rendered, specifically but not limited to:

- Fees for dental services are due, in full, when rendered; and
- Fees for prosthodontic (dentures) and cast restorations (crowns, in-lays, on-lays, veneers) are due at the preparation/impression visit.
- Membership fees are not transferrable
- Payment plans can be made upon request and depend on the total amount due and type of dental procedure. Patients using a payment plan or interest free payment options shall have their membership savings customized to their financial needs.
- There are no refunds on membership fees WHEN any treatment provided equals or exceeds the costs of the membership fee.

Please be sure to retain a copy of your EOB and Exclusions pages for your personal records.

If I, _____ choose not to pay at the time of service, I shall be billed and pay the customary fees for such services. I acknowledge that I am financially responsible for payment, in full, at time of services in order to take advantage of the savings being offered on my membership. If I do not pay, in full, at time of services I understand that I will be required to pay the customary fees for the services delivered regardless of my membership status. Furthermore, I understand the benefits, limitations, exclusions, and requirements of this plan.

SIGNATURE: _____ DATE: _____