Dhakar Family Dentistry

Surya P. Dhakar, D.D.S., P.C.
4440 Springfield Road Suite 101, Glen Allen, VA 23060

Patient Registration Information

Name (Mr./Ms./Mrs./Dr.)_____
First Middle Last

Address_____

City_____ State _____ ZIP _____

Date of Birth _____ Social Security # _____

Are you: ☐ Male ☐ Female

Are you: ☐ Married ☐ Single ☐ Other ☐ Child

Home Phone: _____ Cell Phone: _____

Work Phone: _____ E-Mail Address: _____

Your occupation: _____ Employer: _____
(If Minor, Parents Employer)

If you are a student, name of school/college _____

Whom may we thank for referring you: ☐ Google ☐ Other: _____

Emergency Contact

Name_____ Phone_____ Relationship to Patient _____

Insurance Information *Information of the person to whom the insurance belongs

Do you have insurance? ☐ Yes ☐ No More than one insurance? ☐ Yes ☐ No

Dental Insurance Company_____

Name of Subscriber _____ Date of Birth _____

Social Security # _____ Member ID # _____

Relationship to patient_____ Group #_____

Authorization, Release, and Financial Agreement

I (patient) hereby authorize and consent to dental treatment by Surya P. Dhakar, D.D.S., P.C. I understand the risk and complications associated with local anesthesia and I consent to have local anesthesia as may be necessary during the dental treatment.

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such dental care to third party payers, adjuster, attorney and/or other health practitioners.

DUE TO THE CONSTANTLY CHANGING INSURANCE REGULATIONS, BENEFITS, AND DEDUCTIBLES, THIS DENTAL OFFICE IS ONLY ABLE TO APPROXIMATE MY BALANCE OR CO-PAY ON THE DATE OF SERVICE. I UNDERSTAND THAT MY DENTAL INSURANCE MAY NOT COVER THE DENTAL PROCEDURES AND DENY OR PAY LESS THAN THE ACTUAL BILL FOR SERVICES IN SUCH CASE I WILL BE RESPONSIBLE FOR ANY REMAINING BALANCE.

I agree that my final balance or co-pay be determined after receiving the insurance payment/ explanation of benefits. I agree to be responsible for payment of all services rendered to me or my dependents. I authorize and hereby request my insurance co. to pay directly to the dentist for the dental services provided to my dependent or me. This office allows insurance company up to seven weeks to make payment to the office. If insurance does not pay for any reason within seven weeks then I agree to be responsible for the full charges and pay this dental office immediately.

In the event that I fail to meet my financial obligations or default on payment, I agree to pay attorney or debt collection agency additional forty percent (40%) of the amount due at the time the account is turned over for collection plus court costs and any other expense incurred in collection. I also agree to pay 18 % per year finance charge on the unpaid balance from the date of service.

I realize that failure to keep this account current may result in Surya P. Dhakar, D.D.S., P.C. being unable to provide additional dental services except for dental emergencies.

Late, Missed and Cancellation Policy

If for any reason you must cancel or change your appointment, it is important that you give our office at least 24 hours notice to offer that spot to someone else.

- 1st missed appointment: If an appointment is missed or canceled within the 24 hour window. We also reserve the right to charge you up to $40 for each hour of appointment time scheduled.
- 2nd missed appointment: After your second missed appointment, you will have a change in status of your account. In order for you to schedule a future appointment with our doctors, a deposit must be made. The deposit is $40. Upon arrival, this fee is credited toward the cost of the patient's treatment. If the patient does not show up to the appointment the deposit is non-refundable.

Late arrival: If you arrive more than 15 minutes late, your appointment may be rescheduled in order to meet the needs of those who are on time for their pre-reserved visit. If this happens it will be considered a missed appointment.

After 3 Missed appointments a letter will be sent to the home address dismissing you from our office. You may be seen for emergencies for the next 30 days while you find a new dentist.

Patient/Guardian Signature_____ Date _____