PATIENT REGISTRATION

Dr Michael Krone & Dr John Peroutka
13628 Hull St Rd Midlothian Va 23112 115 N Va St Farmville Va 23901
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NAME_____ DOB_____
ADDRESS_____
CITY_____ STATE_____ ZIP CODE_____
SS#_____ EMAIL_____
PHONE #_____CELL#_____
EMPLOYER_____ EMPLOYER PHONE#_____
INSURANCE_____ INSURANCE #_____

SPOUSE/PARENT_____ DOB_____
SS#_____ EMPLOYER_____

Whom may we contact in case of emergency_____
Phone #_____
PHYSICIAN_____PHONE#_____
Whom may we thank for referring you_____
What are your interest or hobbies_____

Payment at the time of services is expected. For your convenience we accept VISA, MASTERCARD, AMEX,and CARE CREDIT. Our office will be happy to submit claims to your insurance company. A service charge of 1 ½ % per month will be added to all balances 60 days and older. The annual rate of the service charge is 18%.
I understand that the office of Michael Krone DDS will make every effort to collect from my insurance company. I hereby authorize this office to furnish information to to the insurance carriers concerning my treatment and I hereby assign to the dentist all payments for dental services rendered to me or my dependants. I understand that quotes for insurance payments are only estimates. Any overpayments will be immediately refunded and we expect you to immediately pay the balance of any underpayments. By signing this form, I acknowledge and understand that if the account is turned over to an attorney or collection agency for collection, I hereby agree to pay thirty percent (30%) attorney or collection fees on the unpaid balance.
I also understand that all appointments made by me are my responsibility, and without 48 hours notice (2 days) I may be charged a fee which will vary by appointment length and number of appointments missed.

*PATIENT SIGNATURE*_____ *DATE*_____

*Responsible party signature*_____ *DATE*_____