DENTAL WALK IN CLINIC OF TAMPA BAY
4240 W KENNEDY BLVD
TAMPA, FLORIDA 33609
813.636.9400
PATIENT REGISTRATION & INFORMATION, PLEASE PRINT

Patient Name _____ Date of Birth _____
Social Security Number _____
Home Phone _____ Work Phone_____ Cell Phone _____
Email _____
Physical Home Address _____
City_____ State_____ Zip_____
Job Title_____ Employer_____

How did you hear about our office?
Yellow Pages ____ Internet ____ TV ____ Drive By ____Other_____
Referred by another dentist (Please list) _____

Please list family members/persons, if any, who we may inform about your general medical condition and/or diagnosis (including treatment, payment, and health care operations):

_____

Please list family members/significant others, if any, along with a telephone number where they can be reached, whom we may inform about your medical condition
ONLY IN AN EMERGENCY:

_____

Please print the address of where you would like your correspondence from our office to be sent
IF OTHER THAN HOME:

_____

Please print the telephone number where you want to receive calls about your appointments, lab and x-ray results, or other health care information **IF OTHER THAN HOME NUMBER:**

_____

May confidential messages (i.e. appointment reminders) be sent via text, emailed, or left on your telephone answering machine/voicemail? Yes_____ No_____

OFFICE POLICY
PAYMENT IS DUE WHEN SERVICES ARE RENDERED

As a courtesy, we will fill out insurance forms for you so that payment will go directly to you but we cannot be responsible for insurance delays and/or problems. We do not accept payments from insurance companies… all such payments are returned to the insurance companies. Any checks returned for Non-Sufficient Funds or Stop Payments will be charged a $35.00 Returned Check Fee. This fee will be charged to your account and you will not be treated until all balances are paid in full. If we are forced to go to an outside collection agency, litigation, or attorney to collect outstanding balances, you will be liable for all out of pocket expenses as related to your account. You will be charged 1.5% per month on any outstanding balance. You will be reported to all 3 major credit bureaus if your payments are not made in a timely manner. All original x-rays are retained in the office as required by law… Duplicate x-rays are available for a duplicate charge. Please ask.

TO THE BEST OF MY KNOWLEDGE ALL INFORMATION PROVIDED ABOVE IS TRUE. I UNDERSTAND AND ACCEPT MY RESPONSIBILITY TO PAY FOR ALL PROFESSIONAL SERVICES THAT ARE PROVIDED.

Signature of Patient OR Legal Guardian _____
Date _____