Dr. Eric Maser, DMD

30 Orchard Street, Dover, NJ 07801

New Patient Registration – Adult

PATIENT Last Name: _____ First Name: _____ MI: _____ DOB**:** _____

Street: _____ Apt: ____ City: _____ ST: ____ ZIP:_____ SS#: _____

Phone: Home: _____ Cell: _____ Work: _____ □ Married □ Single □ Other

We prefer that you confirm your appointments electronically by email. Please provide your email so we can send appointment reminders. We respect your privacy and will not share this information.
Email _____ @ _____

EMPLOYER: _____ Occupation: _____

Work Address: _____ City: _____ ST: ____ ZIP: _____ Ph: _____

SPOUSE Last Name: _____ First Name: _____ MI: _____ DOB**:** _____

Street: _____ Apt: ____ City: _____ ST: ____ ZIP:_____ SS#: _____

Phone: Home: _____ Cell: _____ Work: _____

SPOUSE'S EMPLOYER: _____ Occupation: _____

Employer Address: _____ City: _____ ST: _____ ZIP: _____

PRIMARY Dental Insurance: _____

Subscriber Name: _____

Relationship to Patient: _____

ID#:_____

Group#:_____

◈ **SECONDARY Dental Insurance**: _____

◈ **Subscriber Name:** _____

◈ **Relationship to Patient:** _____

◈ **ID#:**_____

◈ **Group#**_____

Financial Policy

I understand that I am responsible for all charges incurred for any treatment rendered regardless of insurance coverage, and that payment in full is expected at time of treatment. We will file claims to your insurance on your behalf, but any amount not covered by your insurance is your responsibility and payable immediately. If we have received a predetermination of eligibility from your insurance provider, any deductible and/or charges not covered by your insurance and deemed payable by you are expected at the time of your appointment.

We accept payment in cash, check or debit/credit card. Checks returned for insufficient funds will result in a $35.00 returned check fee.

We require a minimum 24 hours notice of cancellation for all appointments. We reserve the right to charge a cancellation fee of $50.00 for the time that was scheduled for you if an appointment is missed or cancelled with less than 24 hours notice.

Any outstanding balance is due within 30 days of billing. Accounts more than 90 days past due are considered delinquent and will be sent to Savit Collection Agency. Any account sent to collection will incur a charge equal to 20% of the unpaid balance, which will be added to your account.

Thank you for your cooperation in understanding our financial policy. If you have any questions, please feel free to ask us. We will be happy to help you in any way that we can.

I have read and understand the above financial policy and agree to abide by its terms.

Patient Signature: _____ **Date:** _____