Bradley J. Burket, DMD, MD

NEW PATIENT REGISTRATION					
Last Name	First Name	Middle Initial	Employer		Employer Phone
Address			Social Security Number		Home Phone
City, State, Zip					Emergency Phone
Date of Birth	Age	☐ Male ☐ Female		Spouse	

PRIMARY INSURANCE:	SECONDARY INSURANCE:	WORK INJURY:
Insurance Company	Insurance Company	Name and address of employer when injured
Employer	Employer	
Group No. ID No.	Group No. ID No.	
Policy Holder	Policy Holder	Claim No.
Policy Holder's Date of Birth	Policy Holder's Date of Birth	
Date of Injury	Date of Injury	

RESPONSIBLE PARTY – ACCOUNT INFORMATION					
Last Name	First Name	Middle Initial	Employer		Employer Phone
Address			Social Security Number		Home Phone
City, State, Zip					Emergency Phone

MISCELLANEOUS INFORMATION	
Nearest Relative	Phone
Address	
City, State, Zip	
Referred By	Family Doctor

FINANCIAL AGREEMENT

All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage. It is also customary to pay for services when rendered unless other arrangements have been made in advance with our office bookkeeper.

I hereby authorize the doctor to furnish my insurance company all information which the insurance company requests concerning my present illness or injUry. I hereby assign to the doctor all money to which I am entitled for medical and/or surgical expense relative to the services, but not to exceed my indebtedness to the physician and surgeon. It is understood that any money received from my insurance company, over and above my indebtedness will be refunded to me when my bill is paid in full. I understand I am financially responsible to the doctor(s) for charges not covered by this assignment. Charges shown by statements are agreed to be correct and reasonable unless protested in writing within thirty (30) days of billing date. In the event legal action should become necessary to collect an unpaid balance due for medical services rendered to me or my family, I/we agree to pay reasonable attorney's fees or other such costs as the court determines proper. It is agreed that payments will not be delayed or withheld because of insurance coverage or the pendency of claims thereon, and all proceeds of insurance.

A rebilling fee of $3.00 is charged on accounts over (90) days.

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Date Insured or Guardian Signature