LAKEWINDS DENTAL CENTRE
your reason to smile

QDP QUALITY DENTAL PLAN

QDP PATIENT REGISTRATION FORM

LAST NAME: _____ FIRST NAME: _____ MI: _____

ADDRESS: _____ CITY, STATE, ZIP: _____

PHONE: (_____) _____ SECONDARY PHONE: (_____) _ _____

DOB: _____/_____/_____ EMPLOYER: _____

BILLING

PERSON RESPONSIBLE FOR BILL (*ONLY COMPLETE IF DIFFERENT FROM PATIENT*)

RELATIONSHIP TO PATIENT: (CHECK ONE): ( ) SELF ( ) SPOUSE ( ) PARENT

NAME: _____ DOB: _____/_____/_____

SOCIAL SECURITY #: _____ - _____ - _____ ADDRESS: _____

PHONE: (_____) _____ SECONDARY PHONE: (_____) _____

LIST ANY DEPENDANTS:

NAME	DOB	RELATIONSHIP

TOTAL DUE $ _____

METHOD OF PAYMENT (CHECK ONE): ( ) CASH ( ) CHECK ( ) CREDIT/DEBIT CARD ( ) OTHER

PLEASE READ DISCLAIMER AND SIGN BELOW:

Using QDP, in our office, offers significant savings to our patients on dental services rendered, specifically but not limited to:

- The fee paid for our QDP savings plan is for included standard of care services and represents a courtesy accounting adjustment for payment, made in full, at the time of service.
- Fees for dental services/treatment are due, in full, at time of services in order to receive QDP savings; and
- Fees for prosthodontic (dentures) and cast restorations (crowns, in-lays, on-lays, veneers, implants, etc) are due at the prep appointment.
- Quality Dental Savings Plan fees are not transferrable.
- There are no refunds on your QDP Savings Plan Fee **WHEN** any services have been rendered.

Please be sure to retain a copy of your EOB and Exclusions pages for your personal records.

I, _____ acknowledge that I am financially responsible for payment, in full, at time of services in order to take advantage of the savings being offered on my QDP Savings Plan. If I choose not to pay at the time of service, I understand that I shall pay the customary fees for the services delivered. Furthermore, I understand the benefits, limitations, exclusions, and requirements of my QDP program and have been given a copy of my EOB and Exclusion pages for my personal records.

SIGNATURE: _____ DATE: _____ WITNESS: _____