Jason W Eaton DDS MAGD
John J Christensen DDS MAGD

700 North Fairfield Road, Layton Utah 84041
www.advancedentalutah.com

PATIENT REGISTRATION

Patient Name________________________________ Patient Birthdate___________________________ Sex__________

Responsible Person____ Social Security Number______________________

Address_________________________________ City_______________________ State__________ Zip____________

Home Phone_____________________ Work Phone___________________ Cell Phone_________________________

Marital Status__________________________________ Name of Spouse______________________________________

Closest Relative____ Phone______________________________

In Case of Emergency Contact____________________________________ Phone______________________________

Who may we thank for referring you?__________________________________ E-Mail__________________________

Insurance Information

(If you have insurance please complete)

	1st Insurance	2nd Insurance
Insurance	________________	________________
Insurance Address	________________	________________
Insurance Phone Number	________________	________________
Employee/Subscriber Name	________________	________________
Employee/Subscriber ID Number	________________	________________
Employee/Subscriber Birthdate	________________	________________
Group Number	________________	________________
Place of Employment	________________	________________

Payment is expected at time of service unless prior arrangements have been approved.

1. **Cash, Check, MasterCard, VISA, Discover Card, American Express**
2. **Personalized Payment Plans available through CareCredit.** Please ask for an application.

Terms: Interest at the rate of 1 ½ % per month (18% per annum), will be charged on all past due balances. In the event the account is delinquent and satisfactory arrangements have not been made for payment, all legal fees, attorney fees, court cost and collection agency fees of us to 50% of the balance assigned **with or without suit**.
A $60 fee with be charged for missed or cancelled appointments if 24 hour notice is not given.

Signature____________________________________ Date____________________________