CarePoint
ANESTHESIA GROUP
A COMFORTABLE WAY TO A HEALTHY SMILE

ADULT REGISTRATION FORM

PATIENT INFORMATION:

Last Name: _____ First Name: _____

Date of Birth: _____ Gender: M [ ] F [ ] Weight (LBS): _____ Height: _____

Name of Dental Office: _____ Appointment Date: _____

RESPONSIBLE PARTY:

Name: _____ Relationship to Patient: _____

Tel/Cell: _____ Email: _____

Mailing Address: _____

PAYMENT INFORMATION: **[ ] SELF-PAY (Please complete the Financial Agreement on page 2.)**

PRE-OPERATIVE (FASTING) GUIDELINES

Appointments **BEFORE** 11:00 AM:

- ☐ Nothing to eat after midnight the night before
- ☐ May take medication with a SMALL sip of water, 2 hours prior to anesthesia

Appointments **AFTER** 11:00 AM:

- ☐ Nothing to eat **8** hours prior to anesthesia
- ☐ May drink water, apple juice or Sprite only up until 4 hours prior to anesthesia
- ☐ May take medication with a SMALL sip of water, 2 hours prior to anesthesia

I certify that:

- **I have read and understand the fasting guidelines.**
- **CarePoint may communicate patient information using the contact information listed above.**

Signature: _____ Date: _____

CarePoint Anesthesia Group, LLC
8301 East Prentice Avenue, Suite 215
Greenwood Village, CO 80111-2990
Tel: 720-606-4220 ; Fax: 720-606-4221
Email: info@carepointanesthesia.com
Website: https://www.carepointanesthesia.com

ADULT FINANCIAL AGREEMENT

Welcome to CarePoint Anesthesia Group! We are dedicated to providing specialized anesthesia services to the familiar and comfortable environment of your dentist's office, bringing a tailored and personal touch to your care. We would also like to inform you of your financial obligations. The following is our company's financial policy:

FINANCE POLICY: Please **initial** below that you have read, understood, and acknowledge our financial policy.

_____ CarePoint is a "Fee-for-Service" company and payment is due at the time service is rendered.

_____ CarePoint is a completely separate entity from your dentist and that all related fees, operative times and/or orders are charged and billed separately.

_____ For **Adult patients** (21 yrs and older), our minimum fee is $600 per hour. We require a **non-refundable deposit of $500** at the time of scheduling. Payment can be made through our website at ***www.CarePointAnesthesia.com***. Should the dental procedure exceed the allocated 1 hour, an additional $150 per 15-minute increments will be accessed. The remaining balance **will be charged to the card on file unless other arrangements have been made**. We accept all major credit cards, debit cards, Health Savings Account (HSA), flex spending cards, CareCredit (6-months term), cash, money orders, or checks for our services.

I certify that I have read, understood, and acknowledge receipt of a copy of the above Financial Policy. I also understand and acknowledge my financial responsibility for the anesthesia services provided by CarePoint Anesthesia Group, LLC.

Signature: _____ Date: _____

CREDIT CARD PAYMENT AUTHORIZATION

By signing below, you authorize CarePoint to submit payment for any remaining balance due on or after the date of service. Alternatively, card information can be provided through our website in the form of a deposit.

Please check: [ ] **VISA** [ ] **MC** [ ] **AMEX** [ ] **DISCOVER** [ ] **CARE CREDIT** (6-Months Term)

Cardholder Name: _____

Card Number: _____ Expiration Date: ____/____ CVV: _____

Cardholder Signature: _____ Billing Zip Code: _____