Welcome to East Oak Dental

PATIENT INFORMATION FORM

PATIENT

Name (last)_____(First)_____(MI)____

Address_____

City_____State_____Zip_____

Social Security No._____

Home Phone_____

Cell Phone_____

Work Phone_____

Email_____

Sex (M or F)_____Age_____Birthdate_____

INSURANCE / DENTAL PLAN

Subscriber Name_____

Birthdate_____SSN_____

Insurance Co._____

Group #_____

Ins Co. Address_____

Ins. Co. Phone_____Effective Date_____

Employer Name_____

Coverage: Individual____Spouse____Children___Family___

RESPONSIBLE PARTY

(person responsible for the account. If same as PATIENT, please skip.)

Name_____

Relationship to patient_____

Address_____

City_____State_____Zip_____

Home Phone_____

Work Phone_____Text Phone_____

How did you hear about our clinic:

Phone Book (which one)_____

Newspaper____ Radio_____Drive-by_____Mail-out_____

Website, Name_____

Another Patient, Name_____

A Dental Office, Name_____

Other_____

PERSON TO CONTACT IN CASE OF EMERGENCY

Name_____

Relationship_____ Phone_____

I certify that the information provided on this form is accurate to the best of my ability and will be relied upon for providing dental services and billing insurance.

I authorize payment directly to the dentist of any insurance benefits otherwise payable to me. I understand that I am financially responsible for any charges not covered by or paid by my insurance for whatever reason.

I acknowledge that I have received a copy of this dental office's **NOTICE OF PRIVACY PRACTICES.**

I also consent to the use and disclosure of my personal health information by your office for Treatment, Billing/Payment, and Healthcare Operations as outlined in the **NOTICE OF PRIVACY PRACTICES.**

Signature of Patient (or Responsible Party)_____Date_____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

___Individual refused to sign

___Communications barriers prohibited obtaining acknowledgement

___An emergency situation prevented us from obtaining acknowledgement

___Other (please specify)_____

East Oak Dental
Office Financial Policy

We require that all patients, parent, or responsible parties (in the case of a child or minor) read and sign our Financial Policy prior to being seen in our office. Payment is due the day that service is rendered, unless previous financial arrangements have been made. We accept cash, check, major credit cards and CareCredit.

We do accept dental insurance benefits. You are responsible for any remaining balance that your insurance company does not cover.

Please review the following:

- Our estimates are just that, ESTIMATES ONLY. Insurance companies can change coverage amounts, deductibles, etc., without us knowing about it. lf you have received dental services from another dentist or dental specialist, we will not know how much in benefits that you have left for your insurance year unless you inform us. We will try to be as accurate as possible with the information that you provide us.
- Your insurance policy is a contract between you, your employer and the insurance company. We are not responsible for any disputes regarding deductibles, covered charges, secondary insurance and what the insurance company states is a "usual, customary and reasonable fee." We will supply all factual information needed to process your claim.
- Not all services that you may receive are covered by your insurance. This decision is made by the insurance company and the employer.
- Based on the insurance information that we receive from you and what we can confirm with your insurance company, we will estimate your portion for services to be rendered per visit. At the time of each visit, your estimated portion will be due.
- If your insurance company does not pay your claim in 30 days, we may ask you to contact them to expedite payment. If your insurance company has not paid within 45 days we ask that you pay the balance. We will refund to you the insurance payment after we have received it.
- There will be a $25.00 fee for returned checks.

Signature of Patient (or Responsible Party)_____Date_____