# PATIENT REGISTRATION

## Patient Information

First Name: _____Last Name: _____Middle Initial: _____

Preferred Name: _____

Date of Birth: _____/_____/_____ Social Security No.: _____/_____/_____ Gender: ☐Male ☐Female
(SS# REQUIRED - unless you are paying in full with cash OR are under the age of 18)

Address: _____Apt No.:_____ City: _____ State: ____Zip: _____

Home Phone: (_____) _____-_____Cell Phone: (_____) _____-_____ Work Phone: (_____) _____-_____

Email Address _____

What is the best way to reach you during the hour of 9am-5pm? ☐ Home ☐Cell ☐ Work ☐ E-mail

EMERGENY CONTACT:_____Relationship_____ Phone: (_____) _____-_____

How did you hear of our dental practice (referral source)? _____

## Responsible Party and /or Insurance Subscriber (Parent or Guardian)

First Name: _____Last Name:_____ _____Middle Initial: _____

Date of Birth_____/_____/_____ Social Security No. _____/_____/_____ Relationship to Patient: _____
(REQUIRED unless you are paying in full with cash)

Address: _____Apt No.:_____ City: _____ State: ____Zip: _____

Home Phone: (_____) _____-_____Cell Phone: (_____) _____-_____ Work Phone: (_____) _____-_____

## Dental Insurance Information (please provide insurance card and photo ID)

**Primary Coverage**

Insurance Company: _____Phone #: _____

Claims Billing Address: _____

Name of Policy Holder: _____ Policy Holder Date of Birth: _____/_____/_____

Relationship of patient: ☐ Self ☐ Spouse ☐ Child ☐ Other Policy Holder SSN-or-ID#: _____

Policy Holder Employer/Group Name: _____ Policy Group #: _____

**Secondary Coverage**

Insurance Company: _____Phone #: _____

Claims Billing Address: _____

Name of Policy Holder: _____ Policy Holder Date of Birth: _____/_____/_____

Relationship of patient: ☐ Self ☐ Spouse ☐ Child ☐ Other Policy Holder SSN-or-ID#: _____

Policy Holder Employer/Group Name: _____ Policy Group #: _____

## Authorization and Release

I authorize Dr. Jared M. Thompson D.M.D to perform diagnostic procedures, and treatment as necessary for proper dental care.

I authorize release of any information concerning me (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I authorize release of any information concerning my (or my child's) health care, advice and treatment to another referring dentist.

I hereby authorize payment of insurance benefits directly to the dentist, otherwise payable to me.

I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by my dental care payor. I understand that I am responsible for my child's account.

I attest to the accuracy of the information on this page,

Patient or Guardian Signature: _____ Date: _____

# Pacific Oak Dental Financial Policy

Our fees are comparable to the usual and customary fees charged by like general dentists in this area. These charges are based on the cost of materials, as well as the time and skill involved. These fees are not necessarily the same as what your insurance considers "usual and customary."

**Patients with Dental Insurance**

Your dental benefit program will help you obtain and maintain a superlative level of oral health. However, dental treatment is dictated by need, not by insurance coverage. Our recommended treatment is based on correcting existing dental problems, **NOT** on what your insurance will pay for. The benefits specified in you contract are directly related to the amount of insurance coverage that you or your employer have purchased, and bear no relationship to the value of our services. You will be expected to pay for services rendered if this office is unable to verify your insurance information before treatment. If payment for services already rendered has not been paid in full within 45 days, either by you or your insurance company, the remaining balance for treatment is considered due and collectible from you.

**Payment Options**

In order to facilitate the very best health care and keep billing and other fees down, payment is expected at the time services are rendered. You may choose from any of the following: **cash, check, debit, VISA, MasterCard, Discover, America Express and CareCredit** (see details below).

- **Prepay Courtesy (for patients without insurance)**
  A prepayment courtesy of 5% will be subtracted from the total patient obligation (not from co-insurance) if the patient obligation is **paid in full at the first treatment visit** by cash or check.

  **Prepay courtesy does not apply to Credit Card or Care Credit payments, or patients carrying insurance.**

- **Care Credit**
  Care Credit specializes in financing healthcare for patients. Care Credit offers "**no interest" payment plans**, and extended payment plans at a 14.90% interest rate. There is **no prepayment penalty!** Fast approval obtained by filling out an in-office, over the phone, or online application. For additional information please speak with our office manager.

**Appointments**

We make every effort to honor all time commitments and request that you extend the same courtesy to us. If your scheduled appointment cannot be honored, please notify our office so the time can be reserved for another patient.

**We require a 48 hour notice for any cancellations or rescheduling of appointments**. We understand that there are rare circumstances where a 48 hour notice might be unachievable and we will make an exception in those instances. We however reserve the right to charge any and all of these appointments with a standard fee of **$50.00 per hour of scheduled time**. Patients arriving late to their appointments may be rescheduled in order to meet the needs of all our patients.

**Additional Fees**

After collecting your co-insurance and billing your insurance, there is a remaining balance we will send you a send a courtesy statement, if this balance is not paid in full after the first statement you will be charged minimum billing charge of $1.50 per statement. We also reserve the right to apply a finance charge of 18% per year. We reserve the right to forward your account to a third party collection agency if your account is not paid within 90 days. If your account is turned over to a collection agency or an attorney for collections there will be a $110.00 fee and any attorney fees applied to your account in addition to the balance owing on the account. In addition if you remain a patient with our practice after being sent to collections, we will require all services to be paid prior to appointment with cash or credit. A $25.00 fee will be added to cover our cost for any returned checks. In addition we will not accept checks in the future from any person with a returned check history.

**Agreement**

By signing below you acknowledge that you have read and understand your financial options and obligations, and agree to the terms described above.

Patient or Responsible Party Signature _____ Date _____

Pacific Oak Dental

Acknowledgement of Receipt of Notice of Privacy Practices

*You may refuse to sign this acknowledgment*

I, _____, have received a copy of this office's Notice of Privacy Practice.

_____

Signature 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 the acknowledgement

___ An emergency situation prevented us from obtaining acknowledgement

___ Other (please explain) _____