• CLACKAMAS IMPLANT & ORAL SURGERY CENTER • • Brett M. Sullivan, DMD, MD, LLC•
9895 SE Sunnyside Rd, Suite P • Clackamas OR 97015 • (503) 652-8080

Patient Registration

Patient Information

Mr / Mrs / Ms / Dr Name_____ M / F; S / M / D
First MI Last Gender

Birthdate ____/____/_____ Age_____ SS # _____ - _____ - _____ Driver License #_____

Address_____
Street Apt/Suite # City State ZIP

Home Ph #(____)_____ Cell Ph #(____)_____ Work Ph #(____)_____

What is best way to reach you? (please circle one) Home # Cell# Work# E-mail

E-Mail address:_____Attending school? Y / N School_____

Referred by_____ Ph #(____)_____ Family dentist_____ Ph #(____)_____

Employer_____ Occupation_____

Address_____
Street Apt/Suite # City State ZIP

Spousal/Partner Information

If patient is a dependant, also complete top section of Page 2

Name_____ Birthdate ____/____/_____ Age_____ SS # _____ - __

Employer_____ Occupation_____

Work Ph #(____)_____ Cell Ph #(____)_____

IN CASE OF EMERGENCY please contact my parent / relative / friend_____ at (____)_
Circle one Name

Primary Insurance Information

I choose to bill my own insurance. (initial) Date

Dental ☐ Check if none	Medical ☐ Check if none
Insurance company_____	Insurance company_____
Requires preauthorization ☐ Please obtain preauthorization	☐ Requires preauthorization ☐ Please obtain preauthorization
Insured's name_____	Insured's name_____
Insured's Birthdate_____	Insured's Birthdate_____
Insured's SS# or ID #_____	Insured's ID #_____
Relationship to Patient_____	Relationship to Patient_____
Employer_____	Employer_____

Secondary Insurance Information

Dental ☐ Check if none	Medical ☐ Check if none
Insurance company_____	Insurance company_____
☐ Requires preauthorization ☐ Please obtain preauthorization	☐ Requires preauthorization ☐ Please obtain preauthorization
Insured's name_____	Insured's name_____
Insured's Birthdate_____	Insured's Birthdate_____
Insured's ID #_____	Insured's ID #_____
Relationship to Patient_____	Relationship to Patient_____
Employer_____	Employer_____

III. Person Financially Responsible for This Account (Guarantor)

Relationship to Patient:	If same as patient, do not complete this top section.

Mr / Mrs / Ms / Dr Name_____ M / F; S / M / D / W / Other
First MI Last Gender Marital status

Birthdate ____/____/___ Age_____ SS # _____ - _____ - _____ Driver License #_____

Address_____
Apt/Suite # City State ZIP

Home Ph #(____)_____ Cell Ph #(____)_____ Work Ph #(____)_____

Employer_____ Occupation_____ Length of employment_____

Address_____
Street Apt/Suite # City State ZIP

Guarantor Spouse/Partner Information

Name_____ Birthdate ____/____/_____ Age_____ SS # _____ - ____ - _____

Employer_____ Occupation_____ Length of employment_____

Work Ph #(____)_____ Cell Ph #(____)_____

Financial Policy

We recognize that insurance coverage can be confusing. As a courtesy we contact your insurance company to obtain an overview of your insurance benefits. An insurance overview does not guarantee insurance coverage, payment or benefits. Your insurance coverage is a contract between the insurance company and the insured. The patient/guardian is responsible to pay fees for all services rendered, regardless of an insurance company's determination of benefits, authorization and/or payments. Services are not provided on the assumption that the services will be paid for by your insurance company. Patients are responsible to pay the account in full 15 days after the receipt of the insurance explanation of benefit. We encourage you to work with your insurance company to facilitate timely payments in order to avoid interest fees. We charge 1.5% interest per month (ANNUAL PERCENTAGE RATE 18%) on any/all amounts due and payable beyond 60 days from the date of service. Refunds are distributed when treatment is complete and the patient's account has a credit balance.

Financial Responsibility Agreement

I certify the information on pages one and two is correct to the best of my knowledge. I read, understand and agree to the financial policies stated on this page. I have been given no guarantee of insurance coverage, payment or benefits. In the event that the account should become delinquent, I acknowledge that I am liable and responsible to pay all balances, interest, court and attorney fees. I understand that I am primarily liable for payment in full for all services rendered.

I understand payment is required on the day services are rendered. I understand that Clackamas Jaw Surgery accepts Cash, Debit, Visa, MasterCard or Discover payment methods for services rendered.

Patient Signature	Date	Parent/Guardian Signature	Date	Relationship

Authorization for Insurance Billing

I choose to bill my own insurance. (initial) Date

I certify that the information on pages one and two is correct to the best of my knowledge. I choose to have Clackamas Jaw Surgery bill my insurance company for all services rendered. I authorize the release of my records for the purpose of insurance predetermination and to secure payment. I authorize my insurance company to issue payment in full to Clackamas Jaw Surgery and direct the insurance payments to be made directly to the office for all services rendered. I understand that Clackamas Jaw Surgery is a specialty office and it is my responsibility to contact my insurance company and inquire whether a preauthorization and/or a referral from my primary care physician is required for insurance coverage. I understand it is my responsibility to confirm that the required preauthorization or referrals are in place prior to proceeding with treatment. I understand it is my responsibility to provide my insurance company with student status or employment information documentation required to process any claims. I understand that if I am disputing my insurance coverage, I need to contact my insurance company directly. I understand that I am liable and financially responsible for payment in full for all services regardless of my insurance coverage.

Patient Signature	Date	Parent/Guardian Signature	Date	Relationship

☐ My registration information has not changed since my last office visit. Initials:_____ Date:_____