Patient Financial and Insurance Information Form (Please print)

Patient Name_____ Today's date _____
Last First M.I.

Name of Person Responsible for Finances: _____

Address_____
Street City State Zip Code

Home phone #_____ Cell phone #_____ e-mail_____

Birthdate_____ Social Security #_____

Employer_____ Occupation_____

Work Address_____ Work Phone (_____)_____

City_____ State_____ Zip Code_____

Insurance Information – Please initial here if you do not have any insurance _____

1. Primary Insurance Coverage: Name of Insured _____

   Insured's Date of Birth_____SS#_____ Relationship to Patient_____

   Employer_____ City/State_____

   Name of Insurance Company_____ Phone (___)_____

   Address_____

   Group Number _____ ID Number_____

2. Secondary Insurance Coverage: Name of Insured _____

   Insured's Date of Birth_____SS#_____ Relationship to Patient_____

   Employer_____ City/State_____

   Name of Insurance Company_____ Phone (___)_____

   Address_____

   Group Number _____ ID Number_____

Student Status – If you are eligible for any insurance coverage and still in school, including college or graduate school:

If full time student, name of school_____ Grade_____ Year of expected graduation _____

City_____ State_____ Zip code_____

Parent/Legal Guardian (if Patient is under 18 yrs. old)_____

FINANCIAL POLICIES AND INSURANCE PROCESSING PROCEDURES

We value you as a patient, are committed to providing you with the best possible dental care, and want you to have a complete understanding of your financial responsibilities for the services to be provided.

Unless other payment arrangements have been approved in advance by authorized staff, payment in full will be due at the time services are rendered. This includes estimated insurance deductible amounts and copayments. Although we will file your insurance claims at no charge as a courtesy to you, if your insurance company has not paid the full balance of the claim within 60 days from the treatment date, you will be responsible for paying the balance.

For your convenience we accept checks, cash and four major credit cards. We also participate with CareCredit which provides some patients a flexible credit option to cover health care costs. More information about this service may be obtained at www.carecredit.com.

Appointment Cancellation Policy

Your scheduled appointment time is reserved specifically for you. We are aware that unforeseen events sometimes require missing an appointment. In order to meet your needs and the needs of other patients, we request that you call us at least twenty-four (24) hours before your scheduled appointment if you cannot keep it. This will allow us to provide a visit to another patient.

If you do not cancel your appointment at least twenty-four (24) hours in advance, you may be billed a fee of $25.00 for your missed appointment. Please help us serve all our patients better by keeping your scheduled appointment.

Insurance Assignment of Benefits and Authorization for Signature on File:

I recognize that any insurance contracts are between me and the insurance company and it is my responsibility to know my insurance plan policies regarding coverage. Although insurance claims will be filed for me, services are not rendered on the assumption that charges will be paid by my insurance company, and estimated co-payments are due at the time of service.

If I have insurance, I authorize the office of Ocean Grove Family Dentistry to affix my name to any and all claims or documents as related to any and all health benefits due me and my dependents and release any information including the diagnosis and the records of any examination or treatment rendered to me or my child to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to Ocean Grove Family Dentistry any insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services not paid by my dental benefit plan, if any exists. A photocopy of this document may act as an original and my signature hereon will have continuing effect for so long as I am being treated or cared for by Ocean Grove Family Dentistry. In consideration of dental treatment to be rendered to me or my dependents, I agree to sign over every dental benefit payment issued to me for dental services performed by this office within ten business days after receipt from a Dental Service Corporation, Health Service Corporation or Dental Plan Organization, provided, however, that if the amount owed to this office is less than the amount of the dental benefit payment, then only the balance owed shall be paid.

Responsibility for Payment of Account

I am responsible for all charges incurred in this office whether or not I have insurance coverage and understand that payment is required at the time of treatment unless other prior arrangements have been made. I understand that there will be additional charges for returned checks.

_____ _____

Signature of Patient (or parent/legal guardian if patient is under 18 years old) Date