Park Dental Specialists

PATIENT NAME____ MARITAL STATUS: M S D W

ADDRESS____________________ CITY_________________________STATE__________ZIP________

SOCIAL SECURITY NUMBER______________________ DATE OF BIRTH__________________________

HOME #_____________________ BUSINESS #_____________________ CELL#___________________

EMAIL ADDRESS__________________________ OCCUPATION__________________________________

EMPLOYER NAME AND ADDRESS____

RESPONSIBLE PARTY (IF MINOR)_______________________________ RELATIONSHIP ____________________

ADDRESS (IF OTHER THAN PATIENT) ____

PHARMACY_______________________TELEPHONE#_________________LOCATION_______________

EMERGENCY CONTACT_____________________RELATIONSHIP___________ TELEPHONE#_______________

**IS THERE SOMEONE YOU GIVE PERMISSION TO ACCESS YOUR PERSONAL INFORMATION__________________________

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY__________________________ TELEPHONE #_______________________

MEMBER/SUBSCRIBER ID#_____________________________GROUP #__________________________

POLICY HOLDER (***IF OTHER THAN PATIENT***)_______________________ RELATIONSHIP ____________________

SOCIAL SECURITY NUMBER________________ DATE OF BIRTH________ TELEPHONE#_____________________

EMPLOYER NAME AND ADDRESS____

SECONDARY INSURANCE COMPANY__________________________TELEPHONE #____________________

MEMBER/SUBSCRIBER ID#_____________________________GROUP #__________________________

POLICY HOLDER (***IF OTHER THAN PATIENT***)_______________________ RELATIONSHIP____________________

SOCIAL SECURITY NUMBER________________ DATE OF BIRTH________ TELEPHONE#_____________________

EMPLOYER NAME AND ADDRESS____

REFERRAL INFORMATION

WHOM CAN WE THANK FOR REFERRING YOU TO OUR OFFICE?_______________________________________

GENERAL DENTIST____________________________________OFFICE #_________________________

RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

** Payment is due at the time of service, unless prior arrangements have been made with our office. We accept cash, personal checks, American express, Visa and MasterCard. If for any reason you are unable to keep an appointment, 48 hours notice must be given to avoid an additional fee. Default; Patient agrees to pay a monthly rate of 1.5% interest on all unpaid balances 90 days or older.

I authorize the release of all medical information necessary to process my claims and the release of this information necessary to other providers rendering medical/dental care. I assign all medical and surgical benefits, including major medical benefits to which I am entitled, to Park Dental Specialists. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I authorize Park Dental Specialists to send my appointment information via us mail. **I have read the Notice of Privacy Practices for Park Dental Specialists.

SIGNATURE____ DATE________________________

SEE REVERSE

Payment Policies and Agreement

With regard to payment for services rendered, Park Dental Specialists ("PDS") maintains the following policies:

1. While the cost for your surgery is solely an estimate, complicating factors may require additional charges. PDS reserves the right, in the event of complications, to charge a reasonable additional sum above and beyond the foregoing cost quotation.

2. Payment is expected at the time service is rendered unless other arrangements are made in *advance*.

3. As a courtesy, PDS will prepare and submit your insurance forms to your carrier, and will monitor payment of your claim for up to 90 days after submission. 90 days after submission, however, *you will be directly responsible for the payment of any charges which have not by that time been paid by your insurance company.*

4. Be advised that insurance coverage varies, and not all services may be covered. For example, policy terms such as "customary", "reasonable", and "prevailing", are sometimes used to limit coverage. If any of PDS's charges are not paid by insurance*, you will be directly responsible for those unpaid charges, as specified in Paragraph 3.* If you have any questions concerning your insurance claim or your coverage, you must contact your insurance carrier and/or employer.

5. ***Please select the methods in which you would like your statements delivered***:

   Electronic □ *Paper* □ *Both*

   I hereby authorize PDS or its authorized agent to send my statements and disclosures to me electronically. I also agree that this authorization remains in effect until revoked by me, in writing. Initials: ___________

I,_______________________________________, the undersigned, as the party responsible for payment, hereby acknowledge that: (a) I have carefully read the foregoing payment policies: (b) If I request I will be supplied a copy of this completed form: and (c) in consideration for the services rendered by PDS, I expressly agree to abide said policies.

Dated this ____________________ day of ___________________________,20________.

Signature of Party Responsible for Payment:

____

Name of Patient, If Other Than Yourself:

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