PATIENT REGISTRATION

LEGAL NAME_____PREFERRED NAME_____ DOB_____

SOCIAL SECURITY NO_____ MARITAL STATUS: S M W D

STREET ADDRESS_____CITY_____STATE_____ZIP_____

MAILING (LOCAL)_____CITY_____STATE_____ZIP_____

PHONE (H)_____(W)_____(C)_____

SPOUSE/PARENT NAME_____SPOUSE/PARENT OCCUPATION/EMPLOYER_____

EMERGENCY CONTACT_____PHONE_____

REFERRED BY_____E-MAIL ADDRESS_____

PAYMENT

Fees for procedures rendered are due and payable on the day of service unless dental insurance is involved. We are not contracted with any dental insurance company nor Medicare or Medicaid. We are considered an "Out-of-Network Provider" for all insurance companies. We will accommodate our insured patients by completing and submitting insurance claims to their insurance companies for reimbursement directly to the patient. Benefits payments to the patient can be delayed for a few months, especially if both primary and secondary insurance policies are involved. We will carry the balance for up to 45 days and hold the patient's credit card number on file to be charged after the 45 day period when we will call the patient to inform them of the charge. Ask our business administrator about Value Dental Plan or Care Credit financing or visit OrangeBeachDentistry.com (Payment and Insurance) for more information.

RESPONSIBLE PARTY_____RELATIONSHIP_____DOB_____

BILLING ADDRESS_____CITY_____STATE_____ZIP_____

SOCIAL SECURITY NO._____PHONE_____

PAYMENT METHOD: CHECK CASH CREDIT CARD

PRIMARY DENTAL INSURANCE COVERAGE

INSURED NAME_____

EMPLOYER_____

S.S #_____DOB_____

INSURANCE CO._____

ADDRESS_____

CITY/STATE/ZIP_____

CONTRACT/GROUP_____

PHONE_____

SECONDARY DENTAL INSURANCE COVERAGE

INSURED NAME_____

EMPLOYER_____

S.S #_____DOB_____

INSURANCE CO._____

ADDRESS_____

CITY/STATE/ZIP_____

CONTRACT/GROUP_____

PHONE_____

RELEASE

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I authorize release of any information concerning my (or my child's) health care and treatment to another dentist. I hereby authorize payment of insurance benefits directly to the dentist otherwise payable to me. I understand that my dental insurance carrier or payor of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payment 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.

PATIENT/ GUARDIAN SIGNATURE:_____DATE_____