Welcome to Coastal Dental Associates

Patient Information

First Name _____ Middle Initial _____ Last Name _____

By what name do you prefer us to call you? _____E-mail address_____

Date of Birth _____ Social Security Number/DL# _____

Please circle: Single Married Divorced Widowed Separated Student

Street Address _____

Mailing Address (if different) _____

Town _____ State _____ Zip_____

Home Phone (_____) _____ Cell Phone (_____) _____

Appointment reminder preferences **(please check all that apply)**: __ Home __ Cell Phone __ Text ____ Email

May we leave messages on your answering machine or voicemail? __ Yes __ No

Whom may we thank for referring you to our practice? _____

Dental Benefits Information

Policy Holder_____ Relationship _____

Date of Birth _____ SSN/Subscriber ID #_____

Is this person currently a patient in this office? Yes No

Name of Employer _____

Insurance Company _____

Insurance Company claims address_____

Phone Number _____ Group ID # _____ Subscriber ID #_____

Secondary Dental Insurance Yes No

If yes:_____

You may discuss my dental/health care with: Health Care provider Insurance ____ Yes ____ No

Spouse: (name) _____ Other family member: _____

Assignment & Release

I hereby authorize (1) *consent to an examination by a dental provider. I understand that if treatment is recommended I will have opportunities to ask questions before accepting or refusing treatment, (2) I authorize the dentist to release any information, including the diagnosis and the records of any treatment or examination provided to me or my child during the period of such dental care, to third party payors and/or health practitioners/insurance companies. (3) I authorize the use of my dental records by my dentist in any professional manner that he/she determines, (4)making of videotapes, photographs, intraoral images and x-rays of my dental treatment (collectively "my images") and (5)my dentist use of my images in scientific papers, demonstrations and or presentations without compensation to me. (6) I authorize and request my insurance company to pay directly to the dentist any dental benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services and I am responsible for any balances on my account. Finally. I certify that I have read or had read to me the contents of this form and understand the risks and limitations involved with the dental treatment I am to receive. (7) A photocopy of this assignment is to be considered as valid as the original.*

ELECTRONIC COMMUNICATIONS*. I consent to receiving HIPAA-compliant electronic communications, such as email and text messages regarding treatment, payment and health care operations. I understand that there is no obligation to receive these electronic communications. Message/data rates may apply, and I may opt-out of receiving electronic communications at any time by clicking the unsubscribe link provided in emails, or by replying STOP via text to 6034366997.*

Signature - (patient/guardian)_____ Date -_____

The above named Patient is a minor or unable to pay his/her Uninsured Costs, the undersigned agrees to guarantee the payment of such Uninsured Costs to the Patient's dentist in accordance with his/her payment terms and policies.

Signature - (guarantor of patient) _____ Date- _____

Our office is open from 8am-5pm with a 1 hour lunch break from 1-2pm. We have offset our lunch break to try and accommodate those patients that work during the week and have their lunch hours from 12-1pm.

Your dental appointment is considered confirmed at the time of booking. This means we are reserving time with our doctor, assistant and hygienist, as well as operatory space as required. We will be sterilizing and preparing the operatory space as well as all the equipment and materials required for your procedure. We therefore request that if you are unable to attend the scheduled appointment you contact our office with 48 hours notice to reschedule. There will be a $50 fee assessed for every appointment missed or cancelled within 48 hours notice. As a courtesy we will telephone/email/text you two days prior to your appointment to remind you of the appointment you have booked.

Certainly, emergencies such as illness, etc., do occur and we do not wish to penalize patients for unavoidable situations. However, we do want to discourage repeated abuse of our scheduling process, which is ultimately unfair to those patients who are diligent about keeping their appointments.

PAYMENT OPTIONS

• Payment for professional services is due before or at the time of service.

• You may pay by cash, checks, visa, mastercard or discover.
• You may authorize us to keep your credit card on file to pay for account balances.
• We offer a choice of interest-free or extended payment plans to qualified applicants through our financial partner, **CareCredit**. You must be approved before your appointment or treatment.
• We may require payment in advance to reserve your appointment time for certain services or dentists.
• Any balance on your account after 45 days, whether your insurance has paid or not, is your responsibility.
• Balances over 30 days will accrue a finance charge of 1.5% each month until paid. Any additional fees we incur attempting collection or payment will be added to your account.

REGARDING DENTAL BENEFITS (INSURANCE)

• Your benefits policy is an agreement between you, your employer and your insurance company. You are responsible to us and your insurance company is responsible to you.
• We are happy to help you receive your maximum allowable benefits and will file the claim for you as a courtesy.

• All payments and co-payments are due at the time of service.

• In many cases, we allow your insurance company to pay us directly ("assignment of benefits").
• We reserve the right not to accept assignment of benefits; your insurance company will pay you directly.
• If your carrier pays less than what was expected, denies the claim, or pays you directly, you are responsible to us for payment of the balance.

TREATMENT ESTIMATES AND BENEFITS

• Based on the information we receive from you, your insurance carrier, or benefit information we may have on file for your employer, we will give you an estimate for your treatment costs. These are only estimates.
• **Coastal Dental Associates does not presume to act as a representative of your insurance carrier. We will not know your benefit amounts available until we receive actual payment from your insurance carrier. We can only offer estimates.**

USUAL AND CUSTOMARY FEES

• Few insurance companies attempt to cover all dental costs. Most insurance companies limit the fees for services which they cover. They refer to these fee limitations as "usual and customary".
• These usual and customary fees are often a percentage of the fees for our area and are used to control your employer's costs for the plan.
• If these fees are less than our fees you will be responsible for the difference.

MINOR PATIENTS

• The parent who brings the child to his/her appointment will be financially responsible for any balances, co-payments and fees.

I have read, understand and agree to abide by these terms of these Payment, Insurance and Appointment practices:

Printed Name of Patient or Responsible Party_____

Signature of Patient or Responsible Party _____

Date _____