Oak Grove Dentistry, LLC

INSURANCE

To avoid any misunderstanding regarding dental insurance, we wish our patients to know all professional services rendered are charged directly to the patient or person responsible for payment of fees. As a courtesy to you, we will prepare reports or forms necessary to assist in obtaining benefits due you. We do not render services on the basis that insurance companies will pay our fees.

If you direct the insurance company to pay its share of the cost directly to our office, upon receipt of the insurance payment we will credit your account the amount and promptly refund overpayment. Dental insurance was designed to be an aid in obtaining optimum dental health, it was not designed to be a "pay all."

AUTHORIZATION TO PAY THE PROVIDER

I herby authorize payment directly to the above named provider of the insurance benefits otherwise payable to me for the services described on the attached form.

I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES ON MY ACCOUNT.
A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS VALID AS THE ORIGINAL.

_____ _____

Name Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I have received a copy of this office's Notice of Privacy Practices.

_____ _____

Signature Date

- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collection of your unpaid balance.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims; for additional specialist consultation; or in the event I request my records to be transferred to another dental office.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature_____ Date _____

A B C

PATIENT INFORMATION FOR PATIENTS UNDER 18 YEARS OF AGE

Date_____

Patient's name_____ (Last) (First) (Middle)

Address _____ (Street) (City) (Zip)

Nickname_____ Birthdate_____ Social Security # _____

School_____ Sports/Hobbies_____

Parent or guardian name_____

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

RESPONSIBLE PARTY INFORMATION

Name _____ (Last) (First) (Middle)

Residence _____ (Street) (City) (Zip)

Mailing Address _____ (Street) (City) (Zip)

How long at this address?_____ Home phone_____ Work phone _____

Cell/other phone_____ Email address_____

Previous Address (If less than 3 years)_____

Social Security #_____ Birthdate_____ Relationship to Patient_____

Employer_____ Occupation_____ No. years employed _____

Spouse's Name_____ Relationship to Patient _____

Employer_____ Occupation_____ No. years employed _____

Social Security # _____ Birthdate _____ Work Phone_____

DENTAL INSURANCE INFORMATION

Insured's Name_____ Member ID # _____

Insurance Company_____ Group No._____ Local No. _____

Insurance Co. Address_____ Phone No._____

Do you have dual coverage? Yes_____ No_____ If yes:

Insured's Name_____ Member ID # _____

Insurance Company_____ Group No._____ Local No. _____

Insurance Co. Address_____ Phone No._____

I Certify The Above Is True and Correct To the best of my Knowledge

Parent Signature _____ Date _____

A B C

ADULT PATIENT INFORMATION

Date_____

Patient's name _____
Last First Middle

Residence _____
Street City Zip

Mailing Address _____
Street City Zip

How long at this address?_____ Home phone_____ Work phone _____

Cell Phone_____ Birthdate_____ Social Security # _____

Email Address_____ Marital Status: Single__ Married__ Widowed__ Separated__ Divorced___

Employer_____ Occupation_____ No. years employed _____

Spouse's Name_____ Relationship to Patient_____

Employer_____ Occupation_____ No. years employed _____

Social Security #_____ Birthdate_____ Work Phone _____

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

DENTAL INSURANCE INFORMATION

Insured's Name_____ Member ID # _____

Insurance Company_____ Group No._____ Local No._____

Insurance Co. Address_____ Phone No. _____

Do you have dual coverage? Yes_____ No_____ If yes:

Insured's Name_____ Member ID # _____

Insurance Company_____ Group No._____ Local No._____

Insurance Co. Address_____ Phone No. _____

I Certify The Above Is True and Correct To the best of my Knowledge

Signature _____ Date _____