PATIENT REGISTRATION

Patient's Name _____ Sex: ❑ M ❑ F Birth Date ___/___/_____ Age _____ Today's Date ___/___/_____

Home Address _____ City _____ State _____ Zip _____

Email: _____ Hm Phone (_____) _____-_____ Cell Phone (_____) _____-_____

Occupation _____ How Long Employed _____ Work Phone (_____) _____-_____

Your Employer_____ Your Soc. Sec. # _____-_____-_____

Are you a full time student? ❑ Yes ❑ No If patient is minor we need: Mother's Birth Date ___/___/_____ Father's Birth Date ___/___/_____

Person responsible for account _____ Driver's license # _____ State _____

Name of spouse (Parent if minor) _____ Cell Phone (_____) _____-_____

Spouse's (parent's) employer _____ Spouse's Soc. Sec. # _____-_____-_____ Work Phone (_____) _____-_____

How did you hear about our office? _____ Reason for this visit _____

EMERGENCY INFORMATION: (Relative not living with you) Name _____ Phone (_____) _____-_____

Address _____ City _____ State _____ Zip _____

DENTAL INSURANCE INFORMATION (Primary Carrier)

Insured's Name _____

DOB ____/____/_____ SS# _____-_____-_____

Insured's Employer _____

Insurance Co. _____

Insurance Co. Address _____

Phone # (_____) _____-_____

Group # _____ ID# _____

Second Dental Insurance or Medical Insurance (if applicable)

Insured's Name _____

DOB ____/____/_____ SS# _____-_____-_____

Insured's Employer _____

Insurance Co. _____

Insurance Co. Address _____

Phone # (_____) _____-_____

Group # _____ ID# _____

FINANCIAL POLICY

Thank you for choosing San Antonio Oral & Maxillofacial Surgery Associates, P. A. as your oral surgery provider. We are committed to providing you with the highest quality of care. Please understand that payment of your bill is considered part of your treatment.

Payment is due at the time service is provided. Our office accepts cash, personal checks, MasterCard, Visa, Discover, and American Express.
PLEASE NOTE: Returned checks will be subject to additional fees. In the case it becomes necessary for our office to enlist a collection service and/or legal assistance; you will be responsible for any collection and/or legal charges incurred.

Do You Have Insurance?

- As a courtesy to you we will help you process all your insurance claims. Please understand that we will provide an insurance estimate to you, however it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits ultimately determine the amount paid. We will of course, do all we can to make sure your estimate is as accurate as possible.
- All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company. Our office is not a party to that contract.
- Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office.
- We ask that you pay the deductible and co-payment, which is the estimated amount not covered by your insurance company, by cash check, MasterCard, Visa, Discover or American Express at the time we provide the service to you.
- Insurance payments are ordinarily received within 30-45 days from the time of filing. If your insurance company has not made payment within 45 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time. **After 90 days** if the balance is not paid and arrangements have not been made, the account will be sent to a collection company and a collection fee will be added. **The collection fee is currently 33.3% of the balance**.
- We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.

We thank you for the opportunity to serve your dental care needs and welcome any questions you may have concerning your care or our financial policy.

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO MY DENTAL OFFICE.

PATIENT or Guardian SIGNATURE_____ **Date** _____/_____/_____