Welcome to Coastal Dental Associates

Patient Information

Date: _____

First Name _____ Last Name _____

Nickname: _____ Date of Birth _____

E-mail address_____

Address _____

Town/City _____ State _____ Zip_____

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

Please circle: Single Married Divorced Widowed Separated

Emergency Contact: _____Relationship: _____

Phone: _____

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

Dental Benefits Information

Insurance: _____ Claims zip code: _____

Phone Number: _____ Name of Employer_____

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

Date of Birth of Subscriber: _____ Relationship to Subscriber: _____

Subscriber ID #_____ Group ID # _____

- Secondary Dental Insurance: Yes No

  (If yes) Secondary Insurance:_____ ID# _____

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 844-385-7319. *Patient Signature*: _____

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

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

We ask that you please confirm your appointment via this system so we can adequately prepare for your appointment. We do require a minimum of 24 hours notice if you need to change your appointment to avoid a cancellation fee of $45.

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 as well as referred specialists.* ***(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. 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.* *Patient Signature:* _____

You may discuss my dental/health care with: Insurance Provider: ___ Yes ___ No Medical Provider: ____Yes ___NO

Spouse:_____Other family member (Parent if over 18): _____

Please note: Payment is due at the time service is provided. Our office accepts cash, personal checks, MasterCard, Visa, Discover and CareCredit. Outside financing is available upon request and approval. Any balances on accounts are due no later than 15 days after insurance pays to avoid a late fee.

Please note: A yearly oral evaluation performed by one of our Dentists is mandatory.

Please note: If you have a panoramic x-ray or full mouth series of x-rays that have been taken within the last three (5) years by another dentist, we will be happy to accept those x-rays and save you the additional expense of taking new films. Panoramic x-rays OR Full mouth series will be taken every five years to evaluate bone health/thorough diagnosis and bitewing x-rays will be taken annually to detect inter-proximal decay. All patients are required to have an FMX on file.

Please note: 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 and your insurance company. Our office is not a party to that contract. We will provide an insurance **estimate** to you; however, it is not a guarantee that your insurance will pay exactly as estimated. Insurance coverage is subject to limitations, exclusions, waiting periods, frequency, age restrictions, deductibles and maximums which are your responsibility. Your insurance company and your plan benefits ultimately determine the amount paid. We will do all we can to ensure your estimate is as accurate as possible. Your estimated insurance benefit may differ due to a number of reasons, specifically related to your **Dental Insurance Plan**. All charges you incur are your responsibility, regardless of your insurance coverage.

I have read, understand and agree to abide by these terms of these Payment, Insurance and Appointment practices and provided up to date patient information.

Printed Name of Patient or Responsible Party_____

Signature of Patient or Responsible Party _____

Date _____ 2019