Welcome to Coastal Dental Associates
Patient Registration

Date:

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 (required with insurance) _____

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

We ask that you please confirm your appointment via the Communication System : We do require a minimum of 48 hours notice if you need to change your appointment to avoid a cancellation fee of $60. Initial: _____

Dental Benefits Information

Policy Holder name _____ 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

(Must be checked if you would like our office to submit claims on your behalf)

Spouse: (name) _____ Other family member: _____

_____ _____

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

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 under direct care of a guardian, 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- _____

Coastal Dental Associates is pleased to offer 2 payment options for your convenience. Please let us know which you would prefer.

☐ Option 1: Payment is due in full at the time of service. We accept Visa, MasterCard, Debit, Cash and HSA/FSA. Your payment will be processed and we will submit your dental claim to your insurance carrier, on your behalf. Your insurance carrier will reimburse you via your chosen payment method (direct deposit or check).

☐ Option 2: Assignment of Benefits: Your insurance carrier must allow 'Assignment of Benefits.' We will submit your dental claim to your insurance carrier on your behalf, and you will be responsible for the remaining portion not covered through your insurance. A valid credit card MUST remain on file. This includes dual insurance holders. It is your responsibility to notify Coastal Dental Associates of any changes which affect your credit card account. Your account must remain in 'good standing' and any outstanding/uncollectible balance for more than 60 days will no longer be considered eligible for Direct Billing services offered.

I, _____ authorize Coastal Dental Associates to keep my signature on file and to issue a credit or debit memo to my credit card account for any over and under payment once my insurance portion has been received. I will be notified by telephone/Text if my account is charged or credited within an excess of $150. I give my permission for any claim not paid by my insurance company for myself and any family member listed below to be automatically charged to my credit card. A receipt for this transaction will be sent to you via text/email. If using FSA/HSA please note below and a detailed receipt will be emailed to: _____(email address)

If you do not wish to leave a credit card number on file, Option 1 is your only choice.

Credit Card Type: _____Credit Number last 4 digits:_____Exp:_____ (card stored at time of check in)

Signature: _____ FSA/HSA Yes No

(Option 2) Family members to include for Direct Billing:

_____ _____

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 practices:

Printed Name of Patient or Responsible Party _____

Signature of Patient or Responsible Party _____

Date _____