SRD | SOUTH RIDGE DENTAL

WELCOME TO OUR PRACTICE

PATIENT INFORMATION

Patient Name_____ Today's Date_____ Social Security#_____

Address_____ City_____ State_____ Zip_____

Sex: ☐ Female ☐ Male Birthdate_____ E-mail_____

Home Phone (___)_____ Cell Phone(___)_____ Work Phone(___)_____

Do you prefer to receive calls at: ☐ Home ☐ Cell ☐ Work ☐ No Preference

Status: ☐ Married ☐ Widowed ☐ Single ☐ Minor ☐ Separated ☐ Divorced ☐ Partnered for___ years

Patient Employer/School_____ Occupation_____

Employer/School Address_____ City_____ State_____ Zip_____

Spouse or parent's name_____ Birthdate_____ Employer_____ Work Phone(___)_____

Whom may we thank for referring you to us?_____

Person to contact in case of emergency_____ Phone(___)_____

RESPONSIBLE PARTY/INSURANCE SUBSCRIBER

Name of person responsible for this account_____ Social Security#_____

Relationship to patient_____ Phone(___)_____

Address_____ City_____ State_____ Zip_____

Name of Employer_____ Work Phone(___)_____

INSURANCE INFORMATION

Name of Subscriber_____ Relationship to patient_____

Birthdate_____ Social Security# _____ Employer_____ Work Phone (___)_____

Employer Address_____ City_____ State_____ Zip_____

Insurance Co._____ Group #_____ ID#_____

Insurance Co. Address_____ City_____ State_____ Zip_____

Insurance Co. Phone # _____

PLEASE CHECK HERE YOU HAVE SECONDARY INSURANCE ☐

AUTHORIZATION AND RELEASE

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my Doctor if I, or my minor child, ever have a change in health.

I certify that I, and/or my dependent(s), have insurance coverage with _____
Name of Insurance Company(ies)

and assign directly to Dr. Steven Shaffer, D.D.S. or Dr. Ryan Shaffer, D.D.S. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when the current treatment plan is completed or one year from the date signed below.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

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FINANCIAL AGREEMENT: I understand that services rendered to me by South Ridge Dental are my financial responsibility and that South Ridge Dental will bill my insurance company as a courtesy. I authorize my insurance company to pay my benefits directly to South Ridge Dental and I understand that I will be fully responsible for any outstanding balance on my account. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

I have been given the opportunity to pay my estimated deductible and coinsurance at the time of service. I have chosen to assign the benefits, knowing that the claim must be paid within all state or federal prompt payment guidelines. I will provide all relevant and accurate information to facilitate the prompt payment of the claim by my insurance company.

I authorize South Ridge Dental to release any information necessary to adjudicate the claim, and understand that there may be associated costs for providing information beyond what is necessary for the adjudication of a clean claim.

I also understand that should my insurance company send payment to me, I will forward the payment to South Ridge Dental within 72 hours. I agree that if I fail to send the payment to South Ridge Dental and they are forced to proceed with the collections process; I will be responsible for any cost incurred by the office to retrieve their monies.

I authorize South Ridge Dental to initiate a complaint or file appeal to the insurance commissioner or any payer authority for any reason on my behalf and I personally will be active in the resolution of claims delay or unjustified reductions or denials.

APPOINTMENT CANCELLATION POLICY: I understand that South Ridge Dental has set aside time for my appointments and I agree time is valuable for both of us. Therefore, South Ridge Dental reserves the right to charge up to 20% of my scheduled treatment total for each and every appointment that I miss or cancel without giving South Ridge Dental notice of a minimum of 24 hours prior to my appointment. I agree that I will arrive on time for my appointments, and if I am late to my appointment, South Ridge Dental has the right to reschedule my appointment to another date and time.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ THE FOREGOING, RECEIVING A COPY THEREOF, AND IS THE PATIENT, OR IS DULY AUTHORIZED BY THE PATIENTS GENERAL AGENT TO EXECUTE THE ABOVE AND ACCEPT ITS TERMS.

SIGNATURE OF PATIENT	DATE OF SIGNING
SIGNATURE OF PATIENT'S AGENT	SIGNATURE OF INSURED
RELATIONSHIP TO PATIENT	WITNESS

Payment is due in full at time of treatment unless prior written arrangements have been approved.