Patient Information

Date: _____

Name:

_____
(First) (Middle/Maiden) (Last)

Mailing Addres: _____
(Street, Route, Box or Apartment No.)

_____
(City) (State) (Zip Code)

Telephone: (Home): _____ (Work): _____ (Cell): _____

Email: _____

Date of Birth: _____ Social Security No.: _____ Age: _____

Nearest Relative: _____ Phone No.: _____

Referred By: _____ Dentist: _____

Marital Status: Single _____ Married _____ Divorced _____ Widowed _____ Separated _____

Patient Employed By: _____

Address of Employer: _____ City: _____

Name of Spouse: _____

His/Her Soc. Sec. No.: _____ Date of Birth: _____

Spouse Employed By: _____ Work Phone: _____

Address of Employer: _____ City: _____

Primary Dental Ins.: _____ Subscriber: _____

Secondary Dental Ins.: _____ Subscriber: _____

Do you have Medicare Insurance? _____ YES _____ NO (If yes, please ask for supplemental form)

IF PATIENT IS A MINOR, PLEASE COMPLETE THE FOLLOWING:

Student: Full Time _____ Part Time _____ Name of School _____

Father's Name: _____
Address: _____
Phone: _____ DOB: _____
Employed By: _____
Address of Employer: _____
_____
Work Phone: _____
Father's Soc. Sec. No.: _____

Mother's Name: _____
Address: _____
Phone: _____ DOB: _____
Employed By: _____
Address of Employer: _____
_____
Work Phone: _____
Mother's Soc. Sec. No.: _____

(Please Read & Complete Both Sides)

Financial & Insurance Policy

Implants Northwest
Dr. Daniel R Cullum
Certified American Board of Oral & Maxillofacial Surgery

Payment is required at the time services are rendered, including the initial office visit. For your convenience we accept cash, checks, money orders, VISA, MasterCard, Discover and American Express. We also offer CareCredit but require a minimum charge of $500.

Your insurance policy is a contract between you and your insurance company. Predetermination of insurance benefits with your insurance company may be beneficial, informing you of your financial responsibility before expenses are incurred. With confirmed insurance for surgeries performed in our office, we require an estimated deposit on the day of surgery. We will then bill your insurance company for the remainder of fees; however we cannot guarantee payment of your claim. If your insurance company does not pay the amount quoted on predetermination or after payment determines benefits were not due, you still are responsible for your account in full.

Surgery that has to be performed in a hospital will have additional facility fees and/or anesthesia fees. Additional charges from a lab for pathology evaluation may be incurred if a specimen or biopsy must be submitted.

Charges incurred by minors are the responsibility of the parent in whose home they reside. If another parent maintains insurance as part of a court order arising from separation or divorce, we may choose to work with the insurance company; however a clear understanding of financial responsibility must be agreed upon by all parties prior to treatment.

Sixty (60) days after the first date of treatment, interest charges of 1 1/2 percent per month (18% per year) may be charged on accounts not paid in full. Insurance will be given a maximum of 45 days to respond with payment. Any balance after insurance payment is the responsibility of the Guarantor/Patient. If the account is in default and turned over for collection, I acknowledge that I will be responsible for all reasonable attoreny fees, costs of collection and collection fees in the amount of 35 percent of the amount assigned to collections.

I authorize release of my medical history, examination, treatment or consultation information to my insurance companies, government agencies and other health care providers. I hereby grant permission for the use of any illustrations, photographs or imaging records created in my case, for the limited and specific use of same in scientific and professional publications, journals and presentations at any time following my treatment.

I have read and understand the above and authorize insurance payment directly to Dr. Daniel R. Cullum P.A. I am responsible, as guarantor of this account, to pay any deductible amount, co-insurance or any other balance not paid by my insurance company. I am requesting any credit balance on my account be sent to:
_____.

I certify that the information I furnish is true and correct. I realize it is a crime to give false information on this form.

_____ _____
Patient's Name Patient/Guarantor Signature

_____ _____
Witness Date

Revised Jan. 2016