Patient Information

Preferred Name or Nickname

_____

Marital status

Married Single Child Other

Please circle current status

Telephone confirmations are made a week before and the day before your scheduled appointment. Please list your phone numbers below, so that we may contact you in order to confirm your future appointments.

(_____)_____Home/Cell/Work Please circle

(_____)_____Home/Cell/Work Please circle

(_____)_____Home/Cell/Work Please circle

Which is the best contact number to reach you at, in order to confirm future appointment?

(_____)_____Home/Cell/Work Please circle

Whom may we thank for this referral?

Name: _____

Relationship to patient:_____

Address: _____

Person responsible for account (if other than patient):

Name: _____Relationship to Patient: _____
Address: _____
Phone Number: _____
Employer: _____ Since: _____
Social Security Number: _____

Payments will be made by: ___ Check ___ Cash ___ Credit Card

Payments and General Consent for Radiographs, Study Models and Photographs

I understand that I am responsible for my account, regardless of any insurance coverage that I may or may not have. I also understand that any insurance I may have is an agreement only between me and that insurance company, not with Rosedale Dental. I understand that payment is due at time of service. Therefore, I understand that I am responsible for the estimated patient portion of my balance at the time of service. I understand that any estimated patient portion on my treatment plan is only an estimate. Therefore, I understand that I am responsible for the total balance of any work done, whether or not insurance pays the total balance of its estimate portion. I also understand that the right to accept assignment of insurance benefits is solely at the discretion of Rosedale Dental and may be declined at the time, at which prompt payment for the remaining balance is required by me, the patient.

I understand that if I do not have dental insurance I am responsible for my balance in full at the time of service.

I give permission for my dentist, Dr. Jong Oh DDS, his clinical team and staff to take necessary radiographs, study models and photographs in order to make a complete diagnosis of my dental needs. I also give permission for Dr. Jong Oh DDS and his dental team to use my radiographs, study models and/or photographs for in-office patient education.

I consent to the use and disclosure of my protected health information to obtain payment information in connection with my dental claims.

_____ _____
Patient's/Legal Guardian's Signature Date
(I have read, agreed to and understand the statements above.)

Do you have dental insurance?

Yes / No

If yes, please fill out the insurance information section below.

INSURANCE INFORMATION

Name of Primary Insurance Company _____

Address _____

Phone Number _____

Group/Plan Number _____

Subscriber's Name _____Subscriber's Birthday_____

Subscriber's Employer Name and Address _____

Subscriber's Social Security Number _____

Subscribers Relationship to Patient _____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with

_____

(Name of insurance company)

and assign directly to Rosedale Dental otherwise payable to me for services rendered.

I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits, I authorize the use of this signature on all insurance submissions.

_____ _____ _____

Responsible Party Signature | Relationship to patient | Date

Do you have any additional (secondary) insurance?

Yes / No

If yes, please advise front desk.