EAGLE ORAL SURGERY and IMPLANT CENTER

PATIENT INFORMATION

Patient Full Name: _____ Patient's SSN: _____-_____-_____

Date of Birth: _____ Sex: M_____ F _____ Marital Status S M D W

Street Address: _____ Apt. #: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Work Phone: _____

Email Address: _____ Employer: _____

Emergency Contact Name: _____ Emergency Contact Number: _____

Relationship to Patient: _____

How did you hear about us? _____ Referring Dentist: _____

Preferred Pharmacy: _____ Phone: _____

GUARANTOR/PARENT INFORMATION (If different from above)

Responsible Party Name: _____ Guarantor's SSN: _____-_____-_____

Relationship to Patient: _____ Responsible Party Date of Birth: _____

Guarantor's Address: _____ Apt. #: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Employer's Name: _____

PATIENT'S INSURANCE INFORMATION

<u>*The patient is responsible for providing a current insurance card and valid photo ID at check-in. This section left blank does not guarantee insurance will be probably billed*</u>

<u>DENTAL</u> Insurance Company Name: _____

Insurance Address: _____ City: _____

State: _____ Zip Code: _____ Phone Number: _____

Policy Holder's SSN: _____-_____-_____ Name of Policy Holder: _____ Date of Birth: _____

Insurance ID Number: _____ Group Number: _____

<u>MEDICAL</u> Insurance Company Name: _____

Insurance Address: _____ City: _____

State: _____ Zip Code: _____ Phone Number: _____

Policy Holder's SSN: _____-_____-_____ Name of Policy Holder: _____ Date of Birth: _____

Insurance ID Number: _____ Group Number: _____

<u>SECONDARY DENTAL</u> Insurance Company Name: _____

Insurance Address: _____ City: _____

State: _____ Zip Code: _____ Phone Number: _____ Policy Holder's SSN: _____-_____-_____

Date of Birth: _____Insurance ID Number: _____ Group Number: _____

EAGLE ORAL SURGERY and IMPLANT CENTER

HIPPA (Health Insurance Portability and Accountability) Policy _____ I acknowledge I have received a copy of Dr. Hixson's Notice of Privacy Practices.

All above information is accurate and complete, I understand that I am responsible for any changes to my personal information, Insurance.

X _____

Patient Signature or Responsible Party Date

Important Notice

Please be aware that estimated insurance portions are collected at each visit. Your insurance policy is a contract between you and your insurance company. You are responsible for any unpaid balances, regardless of the original estimate.

As a courtesy, our office will file your claims. All deductibles and co-payments are due at the time of service.

A claim form or a copy of your insurance card is required for our records.

You are responsible for updating any changes in your insurance.

Assignment of Benefits

I authorize the release of necessary information and understand that I am responsible for all dental treatment costs. I hereby authorize payment directly to Jeremy Hixson, DMD at Eagle Oral surgery and Implant Center, LLC of the insurance benefits otherwise payable to me.

Billing Policy, Consent for Treatment and Payment:

We accept cash, check, Visa, Discover, American Express, MasterCard and Care Credit. Returned checks are subject to a $35.00 fee. Aged balances over 60 days are subject to a billing charge of $2.00 per month. Balances not paid within ten days of the due date are subject to a late fee of 5% or $15.00 per service date. A past due balance is any amount owing from a prior visit where an insurance payment has not been received by us within 60 days. If you have a past due balance and wish to receive service, you will be required to pay the past due balance and the new charges at time of service. Credit refunds will not be issued until 30 days after insurance reimbursement is received.

X _____

Patient Signature or Responsible Party Date

EAGLE ORAL SURGERY and IMPLANT CENTER

FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT

I authorize treatment of the person named above and agree to pay all fees and charges for such treatment. I agree to pay all charges for and by members of my family shown by statements, promptly upon presentation thereof. Charges shown by statements are agreed to be correct and reasonable unless protested in writing within 30 days of billing date. In the event legal action should become necessary to collect an unpaid balance due for medical services rendered to my family or me I/we agree to pay reasonable attorney's fees or other such costs as the Court determines proper. It is agreed that all payments will not be delayed or withheld because of any insurance coverage or the pendency of claims thereon, and all proceeds of insurance are assigned to this office where applicable, but without their assuming responsibility for the collection thereof. (A copy of this assignment is as valid as the original.) NOTICE: Do not sign this agreement before you read and agree to the conditions set forth. You are entitled to a copy of this agreement at the time you sign. Keep it to protect your legal rights.

AGREEMENT: The above information is for the purpose of obtaining credit and is warranted to be true. I authorize the creditor or his agent to make a credit investigation, including employment verification. I hereby acknowledge receipt of a copy of this form.

X _____

Patient Signature or Responsible Party Date

Authorization

Ability to Obtain Treatment: I acknowledge that my refusal to sign this authorization will not affect my ability to obtain treatment, nor will it effect my eligiblilty for benefits.

Right to Revoke: I acknowledge the rights granted to me under HIPPA allow me to revoke this authorization at any time, provided that, such revocation is in written format.

Redisclosoure: I acknowledge that any released PHI or ePHI may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

Acknowledgement of receipt of Notice of Privacy Practices (HIPAA)

You may refuse to sign this acknowledgement. I have been made aware that I can obtain a copy of this office's Notice of Privacy Practices and consent to the healthcare operations it describes.

Print the Name of the Patient or Responsible Party: _____

X _____

Patient Signature or Responsible Party Date