Patient Registration

This information is necessary, confidential and must be filled out in blue or black ink.

Name Last First, MI (Preferred Title and Preferred Name) ____/____/____ Today's Date

____-____-____ Social Security Number ____/____/____ Birth Date ____ Age eMail Address

Home Phone Cell Phone Work Phone Other Phone

RESIDENTIAL STREET Address (Required) Street, City, State, Zip

MAILING Address (If Different) Street, City, State, Zip

EMERGENCY Contact Name Street, City, State, Zip Phone(s)

Employer Name Occupation (if Retired or Unemployed, please state that)

Employer Address Street, City, State, Zip Phone

Marital Status: Married ☐ Single ☐ Widowed ☐ Divorced ☐ Date ____/____/____ Separated ☐ Date ____/____/____

Do you have medical or dental insurance? Yes ☐ No ☐ PLEASE PROVIDE YOUR INSURANCE CARD(S) TO OFFICE STAFF

(This office does not accept Medi-Cal, Denti-Cal, CMSP, or Medicare)

Spouse's Information

Name Last First, MI (Preferred Title and Preferred Name) Day Phone

____-____-____ Social Security Number ____/____/____ Birth Date ____ Age eMail Address

Employer Name Occupation (if Retired, state Retired)

Employer Address Street, City, State, Zip Phone

Referral Information

Who referred you to our practice? ☐ Another patient ☐ Dental Office ☐ Medical Office ☐ TV Advertisement

Name of Referring Source _____

Do you have a **primary** dentist other than	Yes☐ No ☐
Dentist's name City Phone number	Last dental exam anyplace: ____/____/____ Last dental "cleaning" anyplace: ____/____/____

Your Comments are Welcomed

Patient Health Information

This information is necessary and confidential. It has a direct bearing on your treatment.

Patient Name Last _____ First, _____ MI _____ (Preferred Name) _____ ____/____/____ Today's Date

____-____-____ Social Security Number ____/____/____ Birth Date _____ Highest Level of Education Attained

Gender (M / F) Circle Family Status (Married, Single, Child, Other) Circle _____ If Other, please state

Height _____ Weight _____ Race _____ or Decline to State (circle)

Serious problems can result from an inaccurate health history. If you need help filling out this form please tell us now. Please check (☑) YES or NO, whichever applies.	**Date:** ____/____/____ (Today's Date)	**Date:** ____/____/____ (Follow-up Date)
Dental History		
What is your current primary dental problem or concern?		
Have you ever been diagnosed with or treated for periodontal disease, pyorrhea, gum disease or other diseases of the mouth?	Yes☐ No ☐	Yes☐ No ☐
Have you had any **serious** trouble with **any** previous dental treatment?	Yes☐ No ☐	Yes☐ No ☐
If **yes** to either of the above, please explain.		
Are you experiencing any discomfort or pain at this time?	Yes☐ No ☐	Yes☐ No ☐
Are you unhappy or dissatisfied with the appearance of your teeth?	Yes☐ No ☐	Yes☐ No ☐
Do you have headaches, ear aches, or neck pain?	Yes☐ No ☐	Yes☐ No ☐
General Medical History		
Are you in good general health?	Yes☐ No ☐	Yes☐ No ☐
Has there been **any** change in your general health in the past year?	Yes☐ No ☐	Yes☐ No ☐
My last medical physical examination was on (approx. date is ok)	____/____/____	____/____/____
Do you have a **primary** physician?	Yes☐ No ☐	Yes☐ No ☐
Physician's name City Phone number		
Are you **presently** under a physician's care?	Yes☐ No ☐	Yes☐ No ☐
For what condition? Physician's name City Phone number		
Have you had **any serious** illness or operation?	Yes☐ No ☐	Yes☐ No ☐
If **yes**, date(s) and explain		
Have you been hospitalized or had a serious illness in the **past 5 years**?	Yes☐ No ☐	Yes☐ No ☐
If **yes**, date(s) and reason(s)		

	Date: ___/___/___ (Today's Date)	Date: ___/___/___ (Follow-up Date)
Cardiovascular System		
Do you have or have you ever had any of the following: (Check) ☐Heart attack ☐Stroke ☐Heart trouble ☐Coronary insufficiency ☐Mitral Valve Prolapse ☐Damaged heart valves ☐Congenital heart disease	Yes☐ No ☐	Yes☐ No ☐
Rheumatic heart disease, heart murmur?	Yes☐ No ☐	Yes☐ No ☐
Chest pain after exertion?	Yes☐ No ☐	Yes☐ No ☐
Shortness of breath after mild exercise?	Yes☐ No ☐	Yes☐ No ☐
Ankles swell? When/why? _____	Yes☐ No ☐	Yes☐ No ☐
Sleep propped up? How many pillows? _____	Yes☐ No ☐	Yes☐ No ☐
Have a cardiac pacemaker?	Yes☐ No ☐	Yes☐ No ☐
Do you have any blood pressure problems?	Yes☐ No ☐	Yes☐ No ☐
If **yes**, please indicate **High** or **Low**	High☐ Low☐	High☐ Low☐
Central Nervous System		
Do you have or have you ever had:		
Epilepsy?	Yes☐ No ☐	Yes☐ No ☐
Fainting spells?	Yes☐ No ☐	Yes☐ No ☐
Seizures?	Yes☐ No ☐	Yes☐ No ☐
Emotional disturbances?	Yes☐ No ☐	Yes☐ No ☐
Do you follow any treatment for a nervous disease or disorder?	Yes☐ No ☐	Yes☐ No ☐
Please state the condition Physician's name City Phone number		
Respiratory System		
Do you have a persistent cough or cold?	Yes☐ No ☐	Yes☐ No ☐
Do you have or have you ever had tuberculosis?	Yes☐ No ☐	Yes☐ No ☐
Is there **any** history of tuberculosis in your family?	Yes☐ No ☐	Yes☐ No ☐
Do you have sinusitis or any sinus trouble requiring surgery?	Yes☐ No ☐	Yes☐ No ☐
Do you have emphysema, chronic bronchitis, asthma, COPD?	Yes☐ No ☐	Yes☐ No ☐
Do you inhale any medications? Orally or Nasally (circle)	Yes☐ No ☐	Yes☐ No ☐
Allergies		
Are you allergic to or have you reacted adversely to:		
Local anesthetic?	Yes☐ No ☐	Yes☐ No ☐
Antibiotics, Penicillin, Sulfa Drugs?	Yes☐ No ☐	Yes☐ No ☐
Barbiturates, sedatives, or sleeping pills?	Yes☐ No ☐	Yes☐ No ☐
Latex, Aspirin, Iodine?	Yes☐ No ☐	Yes☐ No ☐
Codeine or other narcotics?	Yes☐ No ☐	Yes☐ No ☐
Do you have autoimmune disorders? Lupus, Crohn's or other?	Yes☐ No ☐	Yes☐ No ☐
Digestive System		
Do you have **any** stomach or intestinal ulcers?	Yes☐ No ☐	Yes☐ No ☐
Do you have or have you ever had:		
Acid Reflux (GERD)?	Yes☐ No ☐	Yes☐ No ☐
Hepatitis?	Yes☐ No ☐	Yes☐ No ☐
Jaundice?	Yes☐ No ☐	Yes☐ No ☐
Liver disease?	Yes☐ No ☐	Yes☐ No ☐
Have you ever vomited blood?	Yes☐ No ☐	Yes☐ No ☐
Do you have **any** diarrhea NOW?	Yes☐ No ☐	Yes☐ No ☐

	Date: ___/___/___ (Today's Date)	Date: ___/___/___ (Follow-up Date)
Skeletal System		
Do you have or have you ever had:		
Arthritis?	Yes☐ No ☐	Yes☐ No ☐
Inflammatory rheumatism?	Yes☐ No ☐	Yes☐ No ☐
Bone infection?	Yes☐ No ☐	Yes☐ No ☐
Artificial Joint Replacement?	Yes☐ No ☐	Yes☐ No ☐
Osteoporosis or Osteopenia? (brittle thin bones)	Yes☐ No ☐	Yes☐ No ☐
(1) Do you take now or have taken medications known as **bisphosphonate**, **by injection**? Examples: Zometa (zoledronic acid) or Aredia (pamidronate)	Yes☐ No ☐	Yes☐ No ☐
(2) Do you take now or ever have taken medications known as **bisphosphonate**, **orally**? Examples: Fosamax (alendronate), Actonel (risedronate) or Boniva (ibandronate sodium)	Yes☐ No ☐	Yes☐ No ☐
Answer only if you have Osteoporosis or Osteopenia		
Have you noticed any changes in your mouth or jaws?	Yes☐ No ☐	Yes☐ No ☐
Have you had any jaw pain or toothache(s)?	Yes☐ No ☐	Yes☐ No ☐
Have you noticed foul odors, swelling or pus in your mouth?	Yes☐ No ☐	Yes☐ No ☐
Endocrine System		
Do you have diabetes? (if yes, circle one: controlled / uncontrolled)	Yes☐ No ☐	Yes☐ No ☐
Do you have any blood related family member that has diabetes?	Yes☐ No ☐	Yes☐ No ☐
Do you urinate frequently for no apparent reason?	Yes☐ No ☐	Yes☐ No ☐
Are you thirsty very often or do you have a dry mouth?	Yes☐ No ☐	Yes☐ No ☐
Do you have hypothyroidism or hyperthyroidism?	Yes☐ No ☐	Yes☐ No ☐
Hematogenic System		
Do you have anemia, Sickle Cell disease, any blood disorder?	Yes☐ No ☐	Yes☐ No ☐
Is there **any** family history of blood disorders?	Yes☐ No ☐	Yes☐ No ☐
Have you had abnormal bleeding after surgery, extraction, or trauma?	Yes☐ No ☐	Yes☐ No ☐
Have you ever had a blood transfusion? When? _____	Yes☐ No ☐	Yes☐ No ☐
Immunodeficiency?	Yes☐ No ☐	Yes☐ No ☐
Do you have asthma, hay fever or seasonal allergies?	Yes☐ No ☐	Yes☐ No ☐
Do you have or have you had hives or skin rash?	Yes☐ No ☐	Yes☐ No ☐
Urinary System		
Have you had kidney trouble?	Yes☐ No ☐	Yes☐ No ☐
Have you had kidney dialysis?	Yes☐ No ☐	Yes☐ No ☐
Syphilis, gonorrhea?	Yes☐ No ☐	Yes☐ No ☐
Other		
Do you have or have you ever had:		
Tumor or malignancy?	Yes☐ No ☐	Yes☐ No ☐
Chemotherapy or radiation therapy?	Yes☐ No ☐	Yes☐ No ☐
Do you have or have you ever had **any** disease, condition or problem NOT listed above that you think we should know about?	Yes☐ No ☐	Yes☐ No ☐
If **yes** to any of the above, please explain		
Are you **regularly** exposed to **any** radiation or toxic substances?	Yes☐ No ☐	Yes☐ No ☐
Do you have glaucoma?	Yes☐ No ☐	Yes☐ No ☐
If **yes**, has your physician advised you to avoid steroids?	Yes☐ No ☐	Yes☐ No ☐
Are you wearing or do you wear contact lenses?	Yes☐ No ☐	Yes☐ No ☐

	Date: ___/___/___ (Today's Date)	Date: ___/___/___ (Follow-up Date)
Habits		
Do you drink alcohol?	Yes☐ No ☐	Yes☐ No ☐
If **yes**, how much and how often?		
Do you smoke tobacco?	Yes☐ No ☐	Yes☐ No ☐
If **yes**, how much and when did you start?		
Do you use oral tobacco?	Yes☐ No ☐	Yes☐ No ☐
If **yes**, how much and when did you start?		
Do you have a history of recreational drug use?	Yes☐ No ☐	Yes☐ No ☐
If **yes**, explain		
Do you have a history of prescription drug abuse?	Yes☐ No ☐	Yes☐ No ☐
If **yes**, explain		
Your Medications (Please list your medications on the Medication List)		
Do you take drugs prescribed to someone other than yourself?	Yes☐ No ☐	Yes☐ No ☐
If **yes**, explain		
Do you regularly fail to take drugs as prescribed?	Yes☐ No ☐	Yes☐ No ☐
Don't take the medication on the prescribed schedule?	Yes☐ No ☐	Yes☐ No ☐
Don't finish the medications?	Yes☐ No ☐	Yes☐ No ☐
Don't have the prescription filled at all?	Yes☐ No ☐	Yes☐ No ☐
Are you now taking any of the following:		
Anticoagulants (blood "thinning" agents)?	Yes☐ No ☐	Yes☐ No ☐
Antihypertensives (for high blood pressure)?	Yes☐ No ☐	Yes☐ No ☐
Tranquilizers (to relax you)?	Yes☐ No ☐	Yes☐ No ☐
Antidepressants (to elevate your moods)?	Yes☐ No ☐	Yes☐ No ☐
Antipsychotics (to change impaired perceptions of reality)?	Yes☐ No ☐	Yes☐ No ☐
Iodine or iodine containing rinses?	Yes☐ No ☐	Yes☐ No ☐
Aspirin? Full Strength or "Baby Aspirin" 81mg	Yes☐ No ☐	Yes☐ No ☐
Codeine or any other narcotics?	Yes☐ No ☐	Yes☐ No ☐
Steroids?	Yes☐ No ☐	Yes☐ No ☐
Others?	Yes☐ No ☐	Yes☐ No ☐
Has your physician ever told you to avoid certain medications?	Yes☐ No ☐	Yes☐ No ☐
If **yes**, please explain.		
_____		
Other Conditions Not Listed		
_____		
For Women ONLY		
Are you menopausal?	Yes☐ No ☐	Yes☐ No ☐
Are you undergoing hormonal therapy such as HRT?	Yes☐ No ☐	Yes☐ No ☐
Do you currently have problems associated with your menstrual period?	Yes☐ No ☐	Yes☐ No ☐
Are you pregnant?	Yes☐ No ☐	Yes☐ No ☐
If yes, Due Date		
Are you nursing?	Yes☐ No ☐	Yes☐ No ☐
Are you taking oral contraceptives?	Yes☐ No ☐	Yes☐ No ☐

Responsibility Statement

Serious problems can result from an incomplete or inaccurate health history.

If YOU are NOT the Patient, who are you, and why did you fill this out for Patient?

Representative Name Last First, MI (Relationship to Patient: eg. Spouse, Parent, Conservator, Friend, Neighbor)

__ - __ - ____ Social Security Number

__/__/____ Birth Date

____ Age

eMail Address

Home Phone Cell Phone Work Phone Other Phone

WHY did patient NOT fill out this form? (Eg. Minor Child, Conserved, Blind, Illiterate, Dyslexic, Unstable, Inebriated, etc.)

I affirm that I read, write, and speak English fluently, and to the best of my knowledge the information in this form and all attachments is complete and accurate.

Signature of Patient or Representative Date

Signature of Witness Date

Signature of Doctor Date

(Do not write below)

Patient Medication List (Prescriptions, Over-the-counter, and Health Store Products)			
Drug Name	How long have you taken it?	Why do you take it?	Prescribing Doctor's name
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			
19			
20			

☐ check if you take NO medications, supplements, herbs, vitamins, health food products of any kind

Printed Name of Patient

Printed Name of Guardian or Legal Representative

Signature of Patient, Guardian, or Representative

Date

Financial Responsibility Agreement

I expect that reasonable efforts shall be expended to fully disclose all surgical and prosthetic fees prior to treatment; I expect that fee estimates shall be honored for 6 months unless to do so would be unreasonable. I agree that all fees shall be paid in full, in advance, for each stage of surgical and prosthetic treatment as the treatment plan progresses.

I agree that even though this facility may file a claim as a courtesy with my insurance company or any other Third party payer, on my behalf, I agree that responsibility for full payment is mine. I assign all benefits available under all my insurance plan[s] to be paid directly to **Christopher Griffin, DMD** or his assignees on my outstanding bill. I authorize the release of any information for completion of my insurance claims and official requests.

I agree that all charges not paid at the time of service was rendered will accrue interest after 30 days at the lesser of the maximum legal rate or 18% per annum [1.50 % per month]; the minimum interest charge will be $3.00.

I agree that account balances over 60 days past due may be turned over to a collection agency or attorney for collection. When an account is turned over to a collection agency or attorney for collection, I agree that an additional forty percent [40%] charge may be added to the unpaid balance for the costs of collection. I agree to be held responsible for all of the unpaid past due balance including the additional costs of collection.

I agree that if an account is turned over to an attorney, I shall be responsible for reasonable attorney fees and costs of suit as permitted by state law. I understand that outstanding account balances might also be subject to collection terms and conditions in consideration of my continued treatment.

I agree to pay the actual cost incurred for my returned checks plus am administrative charge of $35.00; the Practice may elect instead to report my bad check to the District Attorney for collection.

I understand that there might be fees for filling out disability forms, providing documents and information to Insurance companies or government agencies, certified mailings, and making duplications of patient records, As well as other miscellaneous administrative costs; I agree to pay costs for those services,

I agree that appointments not kept by me or cancelled with less than 24 hour notice may be subject to reasonable cancellation charges. I agree that the reasonable value of services will be as billed, unless objected to, by me, in writing, within five days of statement for payment thereof.

I further agree that a waiver of any breech of any time or condition herein shall not constitute a waiver of any further term or condition.

I affirm that I read, write, and speak English fluently, and I have read, understood, and agree to this Financial Responsibility Agreement.

_____

Printed Name of Patient

_____

Printed Name of Guardian or Legal Representative

_____

Signature of Patient, Guardian, or Representative

Date:_____

Credit Cards & Commercial Financing

If you use or apply for a credit card, line of credit or loan [CREDIT] to help you finance your dental treatment, you should know that:

1. **You do not have to use or apply for CREDIT**; you may pay with cash or by other methods.

2. This CREDIT is not a payment plan with our dental office; it is between you and your lender. **Dr. Griffin does not work for the lender**.

3. Before using or applying for CREDIT, Dr. Griffin will provide you with a written treatment plan that includes the anticipated treatment to be provided and the **estimated** cost of each service.

4. If you use or are approved for CREDIT, it does not change our billing practices; our office will only charge treatment and costs to your account when you receive the treatment or when our office incurs costs. When you choose to pay in advance for future treatment, and this results in a credit balance on your account, that credit balance will be used to pay for treatment and costs as they are incurred thereby reducing the credit balance.

5. A credit balance is refundable to you, less payments for charges and costs, within 15 business days of your request; you remain liable to your lender for your CREDIT agreements[s].

6. **VERY IMPORTANT NOTICE: Fees and charges that you or Dr. Griffin incur in securing or processing your CREDIT are your responsibility. Those charges often are unknown to you and are called ADMINISTRATION FEES, MERCHANT CHARGES, and similar. These charges run from as low as 3% to as much as 15% of what you pay with your CREDIT; YOU are responsible for the payment of those charges, and they will be passed through as costs to you.**

Please carefully read the terms and conditions of any CREDIT offer, including any "promotional offers." You may be required to pay interest on the CREDIT even if the literature promises that it is 'FREE', if you miss a payment or do not pay the amount that you owe to the lender, your missed payments can appear on your credit report and could hurt your credit rating. You could also be sued.

I affirm that I read, write and speak English fluently, and I have read, understood, and agree to this Credit Cards & Commercial Financing Agreement.

_____
Printed Name of Patient

_____
Printed Name of Guardian or Legal Representative

_____ Date: _____
Signature of Patient, Guardian, or Representative

Consent To Use and Disclose Protected Health Information {PHI}

Your protected health information will be used by Christopher T. Griffin, DMD, or disclosed to others for the purpose of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice {TPO}.

You may review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You may review the Notice of Privacy Practice prior to signing this consent. You are not required to sign this form as a condition of treatment, refusal to sign this document will be noted, and that act will be deemed to be same as consenting.

You may request a restriction of the use or disclosure of your protected health information. Chris Griffin, DMD may or may not agree to restrict the use or disclosure of your protected health information. If Chris Griffin, DMD agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the Federal Privacy Standards.

You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Christopher T. Griffin, DMD reserves the right to modify the privacy practices outlined in this notice at any time.

With this consent, Christopher T. Griffin, DMD may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With this consent, Christopher T. Griffin, DMD may mail to my home or other alternative location any items that assist the practice carrying out TPO, such as an appointment reminder cards and patient statement.

With this consent, Christopher T. Griffin, DMD may e-mail to my home or other alternative location any items that assist in carrying out TPO, such as appointment reminder cards and patient statements.

By signing this form, I am consenting to Christopher T. Griffin, DMD's use and disclosure of my protected health information as stated above.

_____.
Printed Name of Patient

_____.
Printed Name of Guardian or Legal Representative

_____. _____.
Signature of Patient, Guardian, or Representative Date

Your Comments Are Welcomed

_____
_____
_____
_____.

Miscellaneous Notices, Discounts, & Commercial Financing

POSITIVE IDENTIFICATION—Every patient must provide a government issued photo ID for verification of identity Except minor children and established residents of nursing facilities.

EXAMINATION- Every doctor has the duty to perform an independent examination including all necessary tests and radiographs irrespective of dental plan limitations or the patient's financial ability. Dr. Griffin thinks that full disclosure of all treatment aspects will benefit patients by giving them a better ability to make informed decisions. Your questions are encouraged.

TREATMENT RECOMMENDATIONS -It is arguable whether treatment[s] recommend by Dr. Griffin are the very best treatment possible, but it is every doctor's duty to inform the patient about really good treatments that are available without respect to patient's ability to pay. It is the doctor's duty to make this information available to the patient before offering compromises. There likely are alternative treatments that are available, and the patient always has the option of doing nothing. Doing nothing is a decision that also has consequences.

ESTABLISHED CASE TYPES -Dr. Griffin's treatment recommendations are designed to conform to appropriate published criteria known as Restorative and Periodontal Case Types.

CONTINUING CARE- Recommended oral hygiene care and exams should be done every 3, 4, 6, or 12 months depending upon many factors. Your decision to have continuing care greatly affects the long-term successful outcome of your treatment.

FEES- In most cases fees that will be presented to you represent fees charged to patients who would be financing treatment; these fees might be negotiable and discountable depending upon other payment arrangements. In some cases, fees represent a contracted dental plan table of allowances and are neither discountable nor negotiable. If you have a dental plan, we will try to give you an estimate of your share of costs; that {guesstimate" does not guarantee benefits.

CASH DISCOUNTS- Discounts for payment in full before treatment starts are offered on a sliding scale of 1% per thousand dollars up to a maximum of 25% at $25,000 and above. Federal law requires that medical ad dental plans must also be given the same opportunity to receive a cash discount; that might reduce the benefits medical and dental plans pay.

FINANCIAL ARRANGEMENTS INCLUDING IN-OFFICE FINANCING—All arrangements to pay other than in full at the time for service must be made in advance; credit is NOT automatically granted. Checks returned for any reason may be subject to a $35.00 administrative charge and accrued bank charges; checks might also be turned over to the Greenwood County District Attorney for collection.

Dental Plan Coverage

Primary Dental Plan (information about the party who is providing coverage)

Patient's relationship to covered person: Self ☐ Spouse ☐ Child ☐ Other ☐ _____ ___/___/___ Today's Date

Name Last First, MI Day Phone

Social Security Number ___/___/___ Birth Date Age eMail Address

Employer Name Occupation (if Retired, state Retired)

Employer Address Street, City, State, Zip Phone

Insurance Co. Name ID#/Group Number

Medical Plan Coverage

Primary Medical Plan (information about the party who is providing coverage)

Patient's relationship to covered person: Self ☐ Spouse ☐ Child ☐ Other ☐ _____

Name Last First, MI Day Phone

Social Security Number ___/___/___ Birth Date Age eMail Address

Employer Name Occupation (if Retired, state Retired)

Employer Address Street, City, State, Zip Phone

Insurance Co. Name ID#/Group Number

Secondary Coverage

Dental Plan or Medical Plan (circle which) (information about the party who is providing coverage)

Patient's relationship to covered person: Self ☐ Spouse ☐ Child ☐ Other ☐ _____

Name Last First, MI Day Phone

Social Security Number ___/___/___ Birth Date Age eMail Address

Employer Name Occupation (if Retired, state Retired)

Employer Address Street, City, State, Zip Phone

Insurance Co. Name ID#/Group Number

Insurance Notice

PLANS will be billed one time as a courtesy; if your plan requires additional information, we will provide it. If they want repeat billings, this might actually be delaying tactics in settling your claim.

You will be given excellent treatment options regardless of your plan limitations. Medical and dental plans are obligated to pay benefits only within their contractual limits and should not be permitted to dictate Patient's treatment or decisions.

I affirm that I read, write, and speak English fluently, and I have read and understood this Insurance Notice.

_____ _____

Signature of Patient, Guardian, or Representative Date