

Patient Name: _____

First

M.I.

Last

Preferred Name

Gender: Male Female Married Single Minor Divorced

Patient's SS#: _____ Patient's DOB _____

Address: _____

Street

Apt/Suite#

City

State

Zip

Email: _____

Cell Phone

Work Phone

Home Phone

Employer: _____ Occupation: _____

Whom may we thank for referring you to our practice? _____

If patient is a minor or full-time student, please complete the following:

Mother's Name _____ SS# _____

Cell Phone

Work Phone

Home Phone

Employer: _____ Occupation: _____

Father's Name _____ SS# _____

Cell Phone

Work Phone

Home Phone

Employer: _____ Occupation: _____

Billing Statements and any correspondence should be sent to:

Please file the following dental insurance for benefits on my behalf:

Insurance Plan Name _____

Insurance is offered through the following employer: _____

Subscriber's Name _____

Subscriber's SS# _____ Subscriber's DOB _____

Patients are responsible for knowing and understanding the benefits and limitations of their insurance plan.

EmergencyContact _____ Relationship _____

Phone _____

In the event that prescriptions are needed and must be called in, please provide the following information:

Pharmacy Name: _____

Pharmacy Address: _____

Pharmacy Phone Number: _____

Authorization

I. General Consent to Treatment:

I agree and consent to the performance of diagnostic and therapeutic procedures deemed necessary by Dr. Carmen. I acknowledge that there are no guarantees, expressed or implied, as to the results of any procedures or dental treatment.

II. Release of Information:

I authorize agents of Dr. Bobby Carmen providing services on my behalf to release all billing and medical/dental information to other providers whom I may be referred to for follow-up care, the insurance company, employer or person acting on behalf of a preferred provider arrangement or third party affiliated with the patient's care when such information is requested for payment, utilization review or coverage determination purposes. I understand that this authorization will remain in effect unless revoked by me in writing and delivered to this office.

III. Assignment of Insurance or Third Party Coverage:

I authorize any third party payor to pay directly to this office all benefits due and payable as a result of services rendered.

IV. Acknowledgment of Responsibility to Pay for Services:

I understand that Dr. Carmen, as a courtesy, will file claims with insurance carriers and third party payors. However, I acknowledge and agree that, except as provided by law, and in consideration of the services provided, I will pay any charges which, for any reason are not paid by any third party payor unless there is a specific written agreement between the doctor and the patient and the payor.

V. Health Insurance Portability and Accountability Act:

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at (405) 364-2200.

VI. Administrative Fees: A \$5.00 late fee will be added to statement each month when not paid by the due date. A \$25.00 fee will be assessed for all missed appointments without prior notification. If it becomes necessary to enforce this guaranty by suit or by third party collectors, the undersigned agrees to pay Dr. Bobby Carmen the balance due plus any and all costs, attorney fees and reasonable expenses of collections.

Signature below is acknowledgement that you have received this notice and agree to the provisions therein.

Date _____ Patient Signature _____

Printed Name _____

Parent/Guardian Signature (if Minor Patient) _____

Printed Name _____