Patient registration

DATE____________ NAME__________________________

PREFERRED NAME________________________

ADDRESS_____________________ CITY_____________ STATE______ ZIP_______

HOME NUMBER____________ WORK_____________ CELL_____________

D.O.B.____________ S.S.N.____ ___ ____ AGE ________ MALE__ FEMALE__

MARRIED__ SINGLE__ DIVORCED__ WIDOWED__

EMPLOYER___________________________________

PREVIOUS DENTIST________________________ LAST VISIT__________________

***A 24 hour notice is required for all cancellations. A $75 fee will be charged to your account if advanced notice is not given.**

Patient signature____

PATIENT'S SPOUSE IF MARRIED

NAME__________________ S.S.N.____ ___ ____ D.O.B.___________

EMPLOYER__________________ EMPLOYER'S PHONE NUMBER____________

CELL NUMBER _______________

IF THE PATIENT IS A MINOR, PLEASE COMPLETE:

FATHER'S NAME__________________ S.S.N.____ ___ ____ D.O.B.___________

ADDRESS________________ CITY__________________ STATE___ ZIP________

EMPLOYER_________________ EMPLOYER'S PHONE NUMBER____________

HOME NUMBER_______________ CELL_____________________

MOTHER'S NAME_______________________ S.S.N.____ ___ ____
D.O.B.___________

ADDRESS________________ CITY__________________ STATE___ ZIP________

EMPLOYER_________________ EMPLOYER'S PHONE NUMBER______________

HOME NUMBER_______________ CELL_______________

DENTAL INSURANCE

PRIMARY CARRIER

EMPLOYEE______________________ D.O.B._______________ S.S.N.____ ___ ____

INSURANCE COMPANY____________________ I.D. NUMBER_________________

GROUP NUMBER_______________ INS.PHONE NUMBER_______________

SECONDARY CARRIER

EMPLOYEE______________________ D.O.B._______________ S.S.N.____ ___ ____

INSURANCE COMPANY____________________ I.D. NUMBER_________________

GROUP NUMBER_______________ INS.PHONE NUMBER_______________

IF I RECEIVE INSURANCE PAYMENT FOR DENTAL SERVICE PERFORMED AT PLEASANT GROVE FAMILY DENTISTRY, I WILL ENDORSE THE CHECK IMMEDIATELY, ALONG WITH A COPY OF THE E.O.B., TO 4330 MCKNIGHT RD.

X____________________________

GETTING TO KNOW YOU

IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE? Y__ N__

IF SO, THEIR NAME____________________________

REFERRED TO US BY___________________________

PERSON TO CONTACT FOR EMERGENCY___________________

PHONE NUMBER_____________________

ADDRESS_________________ CITY_________________ STATE___ ZIP_______

CLOSEST RELATIVE NOT LIVING WITH YOU_________________

ADDRESS________________ CITY______________ STATE_____ ZIP__________

PHONE NUMBER ___________________

PLEASANT GROVE FAMILY DENTISTRY

Milburn S. Haynes, D.D.S.
Torin M. Marracino, D.D.S.
4330 McKnight Road
Texarkana, Texas 75503
(903) 838-9700

INSURANCE

A. We are happy to accept your co-payment **on the day of service**, file your PRIMARY insurance that same day and wait **six weeks** for insurance payment. We will make ONE inquiry during that time for you if it is not paid within the first 4 weeks. After that time, you will be responsible for the entire balance, as well as further correspondence with YOUR insurance company for reimbursement to you. If you have a secondary policy, we will be happy to file that for YOUR reimbursement, but that estimated payment does not affect your initial co-payment due on the day of service.

B. **What will YOUR particular policy pay?** As a service to you, we study the different plans and attempt to estimate as closely as possible what YOUR policy will pay on each visit. Clinical recommendations for dental appointments may not correspond to insurance payment guidelines. Ex: dental frequency dates and maximums. There are MANY different **insurance companies**, each offering several different **plans**. The various plans have unique USUAL AND CUSTOMARY price allowances (averaged using a formula across urban and rural areas). These many different USUAL AND CUSTOMARY allowances are **set by insurance companies, and do not, in any way, affect our prices.** It is your responsibility to be aware of your personal insurance or Medicaid requirements and to schedule accordingly. You will be required to pay any expenses not covered by your insurance.

After I make the initial estimated co-payment and my insurance responds with a payment or denial, I understand that I may have either a credit or a balance. Even though I have made and initial payment on the charges, I understand that I am responsible for payment of any balance that insurance does not pay.

I hereby authorize payment directly to Pleasant Grove Family Dentistry of the group insurance benefits otherwise payable to me.

By signing this form I am acknowledging that I have read the above information and have been given the chance to ask questions on any information I do not understand.

____

Signature

Pleasant Grove Family Dentistry
Torin Marracino, D.D.S.
4330 Mc Knight Rd.
Texarkana, Tx.75503

Thank you for choosing Pleasant Grove Family Dentistry as your dental provider. The following is a statement of our Financial Policy, which we require that you read and sign prior to any treatment or office visit.

1. Deductibles, **ESTIMATED** Co-Pays and any uncovered services are due at the time of service. You will be responsible for any remaining Co-Pay after insurance has paid.

2. There will be a charged added to your account on any unpaid balance.

3. You will be considered SELF-PAY until a copy of your insurance is provided.

4. As a **courtesy** we file to your primary and secondary insurance companies, when supplied with the current insurance information.

5. Minor- The adult accompanying the minor will be responsible for payment.

______________________________ ______________________________

Patient’s signature Parent/Guardian Signature (if minor)

____

Date

PLEASANT GROVE FAMILY DENTISTRY
Torin Marracino, D.D.S.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Patient's Name:______________________________________ *Date of Birth*:___________________

SSN:___________________________ *Previous Name*:______________________________________

My personal health information is private and confidential. I understand that my doctor and his staff work very hard to protect my privacy and preserve the confidentiality of my personal health information. I understand that my doctor and his staff may use and disclose my personal health information to help provide health care to me, to handle billing and payment and to take care of other health care operations. There will be no other uses and disclosures of this information unless I permit it. However, I understand that sometimes the law may require the release of this information without my permission. I can ask my doctor to limit how my personal health information is used and disclosed to carry out treatment, payment or health care operations. I understand that my doctor does not have to agree to my request. If my doctor does agree to my request, I understand that my doctor and his staff would follow the agreed limits.
I may cancel this consent at any time by doing the following:

> Writing, signing and dating a letter to my doctor that states that I want to cancel my consent to authorize the use and disclosure of my personal health information for treatment, payment and health care operations.

If I cancel this consent, my doctor and his staff do not have to provide any further health care services to me. My doctor has a detailed document called the Notice of Privacy Practices "Notice". It contains more information about the policies and practices protecting my privacy. I understand that I have the right to read the Notice before signing this agreement. My doctor may update his Notice. If I ask, my doctor or his staff will provide me with the most current Notice. My signature below indicates that I have been given the chance to review a current copy. My signature means that I agree to allow my doctor to use and disclose my personal health information to carry out treatment, payment and health care operations.

I hereby request and authorize the release of all information, without limitations regarding any physical and mental conditions, and revealed by your observation or treatment, past, present or future. This includes medical/dental history, x-ray findings, diagnosis, prognosis and access to all hospital records and photocopies of the same.

I also request the payment of authorized insurance company benefits be made on my behalf to Dr. Milburn Haynes for any services furnished me by that physician/supplier. I authorize any holder of medical information about me to release to insurance companies or their agents any information needed to determine these benefits payable to related services. I understand my signature requests that payment be made and authorizes release of medical information needed to pay the claim. Full charges are sent to my insurance company; I am responsible for deductible, coinsurance and non-covered services. Insurance payments and the deductible are based upon the determination of my insurance company and are independent of amounts charged by Pleasant Grove Family Dentistry.

List all family members, friends and/or physicians who are authorized to call and receive test results and information concerning your health care from this facility.

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____ __________________________
Patient's (or Legal Guardian's) Signature *Date*

____*Relationship to patient (parent, legal guardian, etc.)*