Matthew Speedy Bahen, DMD

Patient:

Name: _____

Date of Birth: _____ SSN: _____

Address: _____

City: _____ St: _____ Zip: _____

Phone: _____

Email: _____

Responsible Party:

Name: _____

Date of Birth: _____ SSN: _____

Address: _____

City: _____ St: _____ Zip: _____

Phone: _____

Email: _____

Emergency Contact Name: _____ **Relationship:** _____ **Phone:** _____

Whom may we thank for referring you? _____

Insurance Primary:

Relationship to patient: _____

Subscriber Name: _____

Subscriber Date of Birth: _____ SSN: _____

Subscriber Address: _____

City: _____ St: _____ Zip: _____

Subscriber Phone Number: _____

Insurance Name: _____

Employer Name: _____

Insurance Phone Number: _____

ID Number: _____ Group Number: _____

Insurance Secondary:

Relationship to patient: _____

Subscriber Name: _____

Subscriber Date of Birth: _____ SSN: _____

Subscriber Address: _____

City: _____ St: _____ Zip: _____

Subscriber Phone Number: _____

Insurance Name: _____

Employer Name: _____

Insurance Phone Number: _____

ID Number: _____ Group Number: _____

HIPAA

I, _____, give consent to the doctor's or designated staff's use at Emerald Valley Dental to disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment, referral to other healthcare professionals and healthcare operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.

I would like a copy of this office's "Notice of Privacy Practices." ____ Yes ____ No

Financial Considerations

Oral health is a very important part of your medical and overall well-being. An important part of our mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options
Cash, Check, Visa and MasterCard
We are pleased to offer comfortable, interest-free payments through **Care Credit.** Payment arrangements are subject to credit approval. Applications available on request.

Insurance

We are happy to work with your carrier to directly bill the insurance company for reimbursement for your treatment. Please keep in mind that the insurance relationship constitutes an agreement between the carrier and your employer. As such, we can make no guarantee of the amount of coverage or payment on your behalf. Please understand, that you will be responsible for any estimated amounts not covered by your insurance at the time of service. We can only estimate coverage, therefore you are responsible for any amounts due after insurance pays.

I, _____understand that any insurance estimate given to me by this office is not a guarantee of actual insurance payment. I also understand that I am ultimately responsible after 60 days for all charges incurred for dentistry performed in this dental office upon my dependents of myself. I have been given the chance to ask if my insurance is in-network.

My signature below indicates that I have read and understood the above stated INSURANCE/FINANCIALPOLICY.

Signature of Patient:_____ Date:_____

Cancellation Policy

We understand that unplanned issues can come up and you may need to cancel or change an appointment. If that happens, we respectfully ask for scheduled appointments to be canceled at least 48 business hours in advance.

There will be a fee of **$50.00** assessed to your account if a PHONE CALL to cancel an appointment is not received within **48 business hours** of your appointment. We also have the right to terminate our patient- doctor relationship for habitual no-shows.

My signature below indicates that I have read and understood the above stated NO-SHOW/CANCELLATION POLICY.

Signature of Patient:_____ Date:_____