Christine J. Coke, D.D.S., M.D., PA

PATIENT REGISTRATION

In order for us to file insurance claims correctly, please fill in all information.
All patient information is confidential.

PATIENT INFORMATION Today's Date: _____

First Name_____ M.I. ____ Last Name_____

☐ Male ☐ Female Preferred Name_____ Birth Date_____ Social Security #_____

Home Address_____ City_____ State_____ Zip_____

Main Tel. (____) _____ Additional Tel. (____) _____ E-mail_____

Employer_____ Employer Address_____ Work Tel. (_____) _____

Emergency Contact_____ Tel. (____) _____ Relationship_____

PRIMARY RESPONSIBLE PARTY (Check one): ☐ Self ☐ Mother ☐ Father ☐ Other: _____

First Name _____ M.I. _____ Last Name _____

Home Address_____ City _____ State _____ Zip _____

Main Tel. (____) _____ Additional Tel. (____) _____ E-mail _____

Social Security #_____ Birth Date _____ Employer _____

Employer Address _____ Work Tel. (_____) _____

OTHER RESPONSIBLE PARTY INFORMATION (*example: other parent*) (Check one): ☐ Self ☐ Mother ☐ Father ☐ Other: _____

First Name _____ M.I. _____ Last Name _____

Home Address_____ City _____ State _____ Zip _____

Main Tel. (____) _____ Additional Tel. (____) _____ E-mail _____

Social Security #_____ Birth Date _____ Employer _____

Employer Address _____ Work Tel. (_____) _____

PRIMARY DENTAL INSURANCE
Insurance Company _____
Policyholder's Name _____
Policyholder's DOB_____
Relationship to Patient _____
ID number _____
Group number_____

PRIMARY MEDICAL INSURANCE
Insurance Company _____
Policyholder's Name _____
Policyholder's DOB _____
Relationship to Patient _____
ID number _____
Group number _____

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FINANCIAL POLICY

Thank you for choosing Christine J. Coke, DDS, MD, PA as your oral surgery provider. We are committed to providing the best dental and medical care possible. Please understand that payment of your bill is considered a part of your treatment. The following statement explains our Financial Policy which we ask you read, sign and return to us prior to your treatment.

All patients should provide accurate and complete personal and insurance information prior to being seen by the doctor.
PLEASE PROVIDE BOTH YOUR DENTAL AND MEDICAL INSURANCE CARDS ALONG WITH A PHOTO ID

1. All applicable co- pay and personal balances, both current and prior, are due at the time of service. We accept checks and credit cards, including CareCredit.

2. We participate in most major dental insurance plans, however, please be aware that some or perhaps all of the services provided may not be considered medically or dentally necessary under your insurance plan. The guarantor, the person who is financially responsible, is personally liable for any amount not covered by insurance.

3. If you have insurance benefits, we will manage your account as follows:

Initials _____ i. No administrative fee will be assessed for filing insurance claims; we will provide this service as a courtesy.

Initials _____ ii. We will research your benefits and estimate your coverage based on our insurance expertise. We do not guarantee our benefit estimates to be correct and are not responsible for benefits that are not paid exactly as estimated.

Initials _____ iii. You are personally responsible for paying deductibles and estimated co-payments on the day of service. You are also personally liable for paying all charges not covered by your insurance plan.

Initials _____ iv. You are personally responsible for balances in full after 90 days. Further insurance appeals beyond the 90-day period are your responsibility. We are not in network with any medical insurance plans.

4. In some cases, your dental policy may require that we submit a claim to your medical insurance for dental procedures. As a courtesy, we will bill both medical and dental insurance for you. If your medical insurance carrier pays for these services, they often apply to your out-of-network deductible. In which case you may be responsible for the full balance if your dental insurance does not subsequently pay their estimated portion.

5. In the event of a credit balance, a refund will be issued to the method of payment that was made at the time of service.

RETURNED CHECKS
A service fee of $25.00 will be charged for all returned checks. If the balance due is not promptly resolved within 7 days of the returned check, collection action will be initiated.

I have read the Financial Policy. I understand and agree with the Financial Policy.

AGREED TO AND AUTHORIZED BY:

Printed Name of Guarantor:	Patient Name:
Signature of Guarantor:	Date:

Christine J. Coke, D.D.S., M.D., PA

HIPPA ACKNOWLEDGEMENT

PLEASE INITIAL THAT YOU HAVE READ:

_____ By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations. You have the right to revoke this consent at any time by giving this office written notice of your revocation. Please understand that we could no longer file insurance claims for you and that it will not affect any action we took in reliance on this consent prior to receiving your revocation and that we may decline to treat or continue treating you if you revoke this consent.

_____ I acknowledge a copy of this office's Notice of Privacy Practices is available to me at my request.

_____ I hereby authorize payment to this practice of the insurance benefits otherwise payable to me and recognize and accept personal responsibility of any remaining balance.

PLEASE CHECK THE FOLLOWING THAT APPLY:

☐ OK to leave a message regarding appointments, insurance information, call back requests, etc. on my home phone and/or cell phone.

☐ OK to leave a message regarding appointments, insurance information, call back requests, etc. with a family member.

☐ OK to leave a message regarding appointments, insurance information, call back requests, etc. on my work phone.

Please list any and all persons we can speak to on your behalf:

_____

_____

_____

_____ _____

Signature of Patient (*Guardian if patient is a minor*) Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____

List explanation above