



**PATIENT INFORMATION**

Date \_\_\_\_\_

Name \_\_\_\_\_ Wishes to be called \_\_\_\_\_

Birthdate \_\_\_\_\_ Soc Sec# \_\_\_\_\_

Male  Female  Minor  Single  Married

Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_

Home # \_\_\_\_\_ Cell # \_\_\_\_\_

Employer \_\_\_\_\_ Work # \_\_\_\_\_ Ext \_\_\_\_\_

Where do you prefer to receive calls?  Home  Cell  Work

E-mail Address \_\_\_\_\_ Referred by \_\_\_\_\_

My Dentist is \_\_\_\_\_

**PERSON RESPONSIBLE FOR ACCOUNT**

Name \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Birthdate \_\_\_\_\_ Soc Sec # \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_

Employer \_\_\_\_\_ Work phone \_\_\_\_\_ Ext \_\_\_\_\_

**DENTAL INSURANCE INFORMATION**

***Primary Dental Insurance***

***Secondary Dental Insurance or Medical PPO***

Insurance Company \_\_\_\_\_

Insurance Company \_\_\_\_\_

Group # \_\_\_\_\_

Group # \_\_\_\_\_

Name of Insured \_\_\_\_\_

Name of Insured \_\_\_\_\_

Employer \_\_\_\_\_

Employer \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insured DOB \_\_\_\_\_ Ins ID# \_\_\_\_\_

Insured DOB \_\_\_\_\_ Ins ID# \_\_\_\_\_

All of the above information is correct. I understand that I am responsible for all costs of dental treatment. I authorize release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or other health practitioners. I hereby authorize payment directly to Aurora Dental Specialists of the insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that as a HIPPA compliant office, the use of cell phones, electronic devices and/or any recording devices is prohibited while in the operatory rooms and/or recovery rooms.

\_\_\_\_\_  
SIGNATURE OF PATIENT OR GUARDIAN

\_\_\_\_\_  
SIGNATURE OF INSURED AND/OR RESPONSIBLE PARTY





## OUR FINANCIAL POLICY

**Thank you for choosing Aurora Dental Specialists. Our mission is to deliver the best oral surgery care available.**

Patients are expected to pay by cash, check, credit card or CareCredit the day that service is rendered unless specific arrangements have been made.

For those patients who are covered by insurance, we accept assignment of benefits. This means that you must sign the portion of your insurance form that "assigns" payments to our office. Most insurance plans do not cover 100% of the cost of treatment. You are expected to pay your **estimated portion** of the charges the day that services are rendered. We will ESTIMATE your portion, but until we actually receive payment from the insurance company, **it is just an estimation.** Insurance benefits quoted may be reduced based on your employer's plan selection and whether we are a participating provider in your plan. You are ultimately responsible for all charges incurred in this office and obtaining information of participation of insurance plans.

For those patients that we are filing with medical PPO insurance, please keep in mind that benefits to be paid will first be applied to your annual deductible and only if they allow medical coverage for wisdom teeth and the position of such teeth. We will assist you in filing with your insurance company, but ultimately the responsibility lies with you.

Please feel free to ask any questions that may remain unanswered either before or after treatment.

I understand and agree to the above financial policy. I acknowledge I have reviewed a copy of this office's notice of privacy practices attached. (HIPPA)

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_  
(Parent or Guardian of a minor)

For patient's that are over the age of 18 and wish to have any information pertaining to treatment and/or payment information shared with their parent/guardian (whether by phone or in person) please sign here as consent to disclose information to the following names:

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

**As a HIPPA compliant office, the use of cell phones, electronic devices and/or any recording devices is prohibited while in the operatory rooms and/or recovery rooms.**