Carrie S. Niemann, D.D.S.

Patient Information

Patient Name: _____ Date:_____
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child How did you find out about our office? _____

Social Security #: _____ Birth Date: _____ Drivers License # _____

Phone (Home): _____ (Work): _____ Ext: _____ (Cell):_____

Email address_____Which phone # is best for reaching you during the day? _____

Address: _____
Street Apartment #

_____
City State Zip Code

Emergency contact_____ Relationship to patient_____ Phone_____

Date of Last Dental Visit_____ Were any x-rays taken? ☐ Yes ☐ No ☐ Not Sure

Responsible Party Information

Name: _____ Relationship to patient_____ Birth Date: _____

Social Security #: _____ DL#_____ Email: _____

Phone (Home): _____ (Work): _____ Ext: _____ (Cell):_____

Address: _____
Street Apartment #

_____
City State Zip Code

Is this person currently a patient in our office? ☐ Yes ☐ No

Insurance Information

Primary

Name of Insured: _____ Birth Date: _____
Last First MI

Home Address: _____Phone#_____
Street City State Zip Code

SSN#_____Employers Name: _____ Employers Phone #_____

Employers Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Insurance Plan Name and Address: _____

Insurance Co. Phone #_____ Insurance Group #_____

Secondary

Name of Insured: _____ Birth Date: _____
Last First MI

Home Address: _____Phone#_____
Street City State Zip Code

SSN#_____Employers Name: _____ Employers Phone #_____

Employers Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Insurance Plan Name and Address: _____

Insurance Co. Phone #_____ Insurance Group #_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. I will be sure to inform this office of any changes. **X** _____ **INITIAL**

Appointment Cancellation and Failure Policy

Our practice is dedicated to quality care and exceptional service. We respect the importance of your time and carefully schedule appointments that accommodate the busy scheduling needs of our patients. In return, we ask that patients make every effort not to cancel reserved appointments. Broken or missed appointments result in scheduling conflicts that could cause a delay in needed treatment. We require a minimum of 24 hours notice when an appointment must be rescheduled. If this policy in not honored, we reserve the right to charge a broken or missed appointment fee. Thank you for your cooperation.

I understand and agree to the above policy concerning appointment cancellations and failures.

X_____ INITIAL

Financial Policy

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are performed.

I understand a fee estimate listed for dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, I agree to pay within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder. I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

Patient's portion is due in full the day of service before any procedure will be performed. Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. If your insurance company has not paid within 90 days, full payment is required from the guarantor immediately.

Our office will attempt to estimate your portion due; however, this is only an estimate. You are responsible for any charges your insurance company does not pay.
A $10.00 billing fee will be charged to your account if we are required to send more than one statement to collect a fee.
Any check returned due to non-sufficient funds will incur a $30 fee.

I agree to be responsible for payment of all services rendered on behalf of myself and my dependents. I hereby authorize payment directly to Coastal Carolina Dentistry, LLC of all benefits otherwise payable to me. Furthermore, I authorize Coastal Carolina Dentistry, LLC to provide my insurance company with any information pertaining to my health and dental care, services rendered, or supplies provided.

I have read the above conditions of treatment and payment and agree to their content.

X _____ Signature of Responsible Party Date_____

X _____ Printed Name of Responsible Party

Consent for Services

I HAVE READ THE HIPAA NOTICE OF PRIVACY PRACTICES AND AGREE TO THE POLICY. X _____ INITIAL

To the best of my knowledge all of the preceding answers and information are true and correct. If I ever have any change in my health, insurance or financial information, I will inform the office without fail.

X _____ Date: _____ Relationship to Patient: _____

Signature of patient, parent, guardian or guarantor of payment/responsible party