Anchor Bay ORAL SURGERY, P.C.

Today's Date: _____

Patient's Name: _____ SS#: _____

Address: _____ City : _____

County: _____ State: _____ Zip: _____ Phone: (_____) _____

Employer: _____ Cell Phone: (_____) _____

Work Address: _____ Work Phone: (_____) _____

City: _____ Zip: _____

Email(Optional): _____

Date of Birth: _____ Sex: _____ Student: _____ Marital Status: _____ Spouse's Name: _____

Who is financially responsible for this account? _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: (_____) _____

Employer: _____ Work Phone: (_____) _____

Emergency Contact: _____ Relationship: _____

Contact Address: _____ Contact Phone: (_____) _____

City: _____ Zip: _____

Who Referred you to our office? Dentist ☐ Physician ☐ Yellow Pages ☐ Other ☐ - Who? _____

Dentist's Name: _____ Physician's Name: _____

IS THERE INSURANCE THAT MAY COVER A PORTION OF THE SERVICE? Yes ☐ No ☐

DENTAL INSURANCE
PRIMARY COVERAGE:

Insurance Name: _____
Employer: _____
Insured's Name: _____
Birth date: _____
Contract/SS#: _____
Group/Policy#: _____

MEDICAL INSURANCE
PRIMARY COVERAGE:

Insurance Name: _____
Employer: _____
Insured's Name: _____
Birth date: _____
Contract/SS#: _____
Group/Policy#: _____

SECONDARY COVERAGE:

Insurance Name: _____
Employer: _____
Insured's Name: _____
Birth date: _____
Contract/SS#: _____
Group/Policy#: _____

SECONDARY COVERAGE:

Insurance Name: _____
Employer: _____
Insured's Name: _____
Birth date: _____
Contract/SS#: _____
Group/Policy#: _____

PLEASE NOTE: PAYMENT IS EXPECTED AT THE TIME THE SERVICE IS RENDERED.
Any question about your insurance coverage or our office policies should be discussed before your appointment.
THANK YOU!

PLEASE REVIEW AND COMPLETE OTHER SIDE

FINANCIAL POLICY – "SIGNATURE ON FILE" DESIGNATION

I understand Anchor Bay Oral Surgery, P.C. is a fee for service office and that I am responsible for payment for all services received. I am aware that a claim will be filed with my insurance company, on behalf of the patient, for all services rendered that arise from this office visit and related office visits. I understand that the amount of insurance reimbursement for services provided is based upon the contract stipulations established by my employer and the insurance company.

I acknowledge that I am responsible to pay Anchor Bay Oral Surgery, P.C., for any services received or required that are not fully reimbursed by the insurance company, for whatever reason. I agree to settle the account in full with Anchor Bay Oral Surgery, P.C., within ten days of notification of the failure of the insurance company to pay. I understand that a finance charge may be applied to any outstanding balance due.

I have read, or had read to me, the above statements and by my signature, I acknowledge that I agree to abide by them. Moreover, I authorize all benefits be assigned and made payable to Anchor Bay Oral Surgery, P.C. If there is no insurance, then I understand that I am responsible for all charges for services received.

_____ _____ _____

Responsible Party's Signature (Patient, Parent or Guardian if Minor) Date Relationship

MICHIGAN DENTAL PATIENT "DISCLOSURE" CONSENT FORM

Michigan Law requires us to obtain your written consent prior to disclosing any of your information except for disclosures in connection with: defense of a claim challenging our professional competence, a review entity's functions, a claim for payment of fees, a third party payer's examination of our records, a court order as part of criminal investigation, an identification of a dead body, a licensure investigation, or a child abuse/neglect investigation.
From time to time it may be necessary for us to make disclosures of your information in connection with your treatment. For example: sending a confirmation of treatment rendered or when making a referral for consultation with another dentist, physician or other health care professional, providing a specimen to a laboratory for testing, or in connection with providing or coordinating your care, including contacting you for appointment reminders and office correspondence. Radiographs and photographs taken may be used for educational purposes.
By signing below, you are providing consent to Anchor Bay Oral Surgery, P.C. and it's representatives, for disclosure(s) of your information that are deemed necessary in order to provide you with appropriate treatment.

_____ _____ _____

Responsible Party's Signature (Patient, Parent or Guardian if Minor) Date Relationship

DISCLOSURE ACCESS TO ADDITIONAL INDIVIDUALS OF YOUR CHOICE

Anchor Bay Oral Surgery, P.C. holds information about you and your care to be private and personal. We will only discuss information about you and your care with you or the legal guardian of a minor or of a patient who has a legal guardian. You have the right to define whom else we may discuss information about you and your care, but that must be specified. Please indicate any person or persons that we may discuss you and your care with. This request may be revoked or altered at anytime by filling out a new form, or in a formal written request.

_____ _____

Name Relationship

_____ _____

Name Relationship

_____ _____

Name Relationship

_____ _____

Name Relationship

I have read and agree to disclosure of information to the above noted individuals when it appears reasonable as defined by Anchor Bay Oral Surgery, PC

_____ _____ _____

Responsible Party's Signature (Patient, Parent or Guardian if Minor) Date Relationship