Patient Registration

What is the reason for the visit?_____

Patient's Name:_____ Age:_____ Date of Birth:_____ ☐Male ☐Female

For Minors: Name of Parent/Guardian: _____ Date of Birth:_____

Address:_____ City:_____ State:_____ Zip:_____-_____

Home#:_____ Cell#:_____ Email:_____

Emergency Contact:_____ Tel# _____

SS#:_____ Occupation:_____

Whom may we thank for referring you?_____

Name of physician?_____

☐ I certify that I am fluent in reading and speaking English. If no, I prefer another language:_____

NOTICE OF PRIVACY

I authorize this office to release medical information to insurance companies and their agents for the purpose of obtaining payment for services and determining insurance benefits.

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

I consent to allow this office to contact me and leave messages at the contact information given above.

FINANCIAL POLICY

I understand and agree that I am financially responsible for all charges whether or not paid by insurance.

I understand that all payments including insurance co-payments and deductibles are due in full at the time services are rendered, including x-rays, consultations and surgical services.

I authorize and assign all insurance payments be made directly to Boca Raton Oral Facial and Implant Surgery LLC.

I acknowledge and agree to be solely responsible for all charges and fees that result from delinquency in payments, these include collection fees, attorney's fees and court costs.

With my signature below, I certify that I have read, understand and agree to the Privacy Practices and Financial Policy above.

Print Name: _____ Signature(Parent/Guardian): _____ Date:_____