Patient Registration

Please fill in completely

Name:_____ Gender: Male Female Date:_____

Address:_____

_

City:_____State:_____Zip:_____

Home Phone: (_ ___)_____Work Phone: (_ ___)_____Cell Phone: (____)_____

E-Mail address:_____ Preferred form of contact: _____

Birth date:_____Social Security Number:_____

Employer:_____

How did you hear about our office?_____

Present dentist:_____

Address:_____Phone:(___)_____

City:_____State:_____Zip:_____

Date of last visit:_____

Present physician:_____

Address:_____Phone(___)_____

City:_____State:_____ Zip:_____

Are you now under the care of a physician? Yes No If yes, for what reason?

Health Insurance Information

Medical Insurance Company:_____

ID#:_____Group #:_____

Subscriber's Name:_____Subscriber's Social Security #:_____DOB:_____

Records release: I hereby authorize the Great Plains Dental to release my information, including diagnosis and records of treatment, concerning my past medical history to my referring physician/dentist or other health care providers, insurance company and immediate family.

Patient (or parent if minor)

Signature:_____Date:_____

Billing and Insurance Policy

Great Plains Dental would like to thank you for choosing us as your provider. We are committed to you and your treatment. Please understand that payment of your bill is considered to be a part of your treatment. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment.

In-network Providers

We are not currently in-network providers for any medical insurance carriers.

Out-of-network Providers

If you have coverage through any other insurance carriers, payment in full will be due at the time of service. We will send all claims to your insurance company and they will send all payments or correspondence to you directly. If needed, we will be happy to assist you in getting reimbursement. Some insurance plans require a referral from your Primary Care Clinic or Physician before you can receive coverage. If your plan requires a referral you will need to contact your Primary Care Clinic to make sure that all appropriate referrals are in place prior to starting treatment.

We strongly recommend that you contact your insurance company prior to treatment to confirm the amount or percent of coverage for your care in our office. Your insurance company may ask you for a CPT or HCPCS code for the treatment. The billing code for an oral apnea appliance is E0486. It is important that you confirm your financial responsibility before we begin treatment to avoid any misunderstandings.

I have read, understand and agree to follow the policies as stated above.

Signature_____ Date_____