Bandon Coastal Dental

Registration Form

PATIENT INFORMATION

Patient Name | Referred by

Social Security Number | Birthdate | Age | Single | Married | Widowed

Mailing Address | City | State | Zip | Home Phone | Mobile Phone

Email

Employer | City | State | Business Phone

TO OUR PATIENTS: Due to the low cost and high quality of dentistry in this office, payment due for services rendered on the day of service. However, we do accept most insurance. All charges billed to insurance or paid in installments will be billed at our usual and customary fees-not the discounted price. Patient is responsible for deductibles and co-pays at the time services are rendered.

DENTAL INSURANCE

Primary Insurance Company Name | Group # | Subscriber Name | Birthdate | Subscriber ID# or SSN#

Secondary Insurance Company Name | Group# | Subscriber Name | Birthdate | Subscriber ID# or SSN#

Assignment and Release:

I certify that I, and/or my dependent(s), have insurance coverage with insurance companies listed above and assign directly to Dr. Andrew J Oas, LLC. all insurance benefits. If any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by Insurance. I authorize the use of my signature on all insurance submissions.

The above mentioned doctor may use my dental care information and may disclose such information to the above named Insurance Company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Signature of Patient, Parent, Guardian or Personal Representative | Date

Please print name of Patient, Parent, Guardian or Personal Representative | Relationship to Patient

In case of Emergency, Contact:

Name | Relationship | Contact Phone Number

Being the patient or legal guardian of the person named in this form, I do hereby authorize and request performance of dental service, and do authorize emergency procedures that the judgment of the doctor may determine to be necessary during treatment.

Patient or Guardian Signature | Date | Doctor Signature | Date | Front Office Initial