ADVANCED
ORAL SURGERY

NEW PATIENT INFORMATION

Patient Name: _____ Nickname/Preferred Name:_____

Birthdate: _____ Gender: ☐ Male ☐ Female Family Status: ☐ Single ☐ Married ☐ Minor

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

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

Email **:** _____

Preferred Pharmacy, Address & Phone Number:_____

IN CASE OF EMERGENCY, CONTACT: Name: _____ Relationship:_____

Phone: ( )_____ Alternate Phone: ( )_____

Referring Doctor: _____

Reason for today's visit? _____

How did you hear about us? Website_____ Newspaper_____ Family/Friend_____ Google_____ Insurance_____ Other_____

FINANCIAL INFORMATION

Person responsible for payment: _____ Relationship to patient: _____

Employer name: _____ Employer phone: ( )_____

Primary Dental Insurance: Name of Insured: _____ Date of Birth: _____

Insurance Company: _____ Phone: _____

ID#: _____ Group number: _____

ASSIGNMENT AND RELEASE FOR DENTAL INSURANCE: I certify that I, and /or my dependents(s) have insurance coverage with _____ and assign directly to Dr. Jason Edwards/Advanced Oral Surgery all insurance benefits, if any, otherwise payable service rendered. I understand that I am financially responsible for all charges whether or not paid by insurance within 60 days. I authorize the use of my signature on all insurance submission.

Dr. Jason Edwards may use my health care information and may disclose medically relevant information to the above-named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____

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

_____ _____

Print name of Patient, Parent, Guardian or Personal Representative **Relationship to Patient**

FINANCIAL POLICY

Revised 06/2023

Payment for services is due at the time services are rendered unless payment arrangements have been approved in advance by this office.

If you have dental insurance, we will work hard to help you receive your maximum allowable benefit. You must take the necessary steps to understanding your insurance plan. Since there are so many different providers and plans, it is impossible for us to know all of our patient's benefits, deductibles, and exclusions. Plan benefits can be obtained by calling your dental insurance company. We will gladly discuss your proposed treatment and answer any questions that you may have relating to your insurance. You, however, must be aware that:

1. Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract.
2. Most insurance companies have a yearly deductible that is your responsibility.
3. Most insurance companies only pay a percentage of the cost (such as 50% or 80%) and you are responsible for the remainder.
4. Not all services are a covered benefit in all contracts. It is important for you to contact your insurance provider and ask if there are any clauses or waiting periods.
5. As a courtesy to you, our office will submit your claim(s) to your insurance provider. If for any reason the claim(s) go unpaid, you will be responsible for all charges.

If you have questions regarding this information or any uncertainty regarding insurance coverage, please ask us, we are here to help in any way we can.

I, _____, am responsible for any and all charges on my account.

HIPAA (Privacy Consent)

I give this practice my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations like quality reviews.

I have been provided the opportunity to review the practice's Notice of Privacy Practices for a description of uses and disclosures before signing this consent.

I understand that this practice has the right to change their privacy practices and that I may obtain any revised notices at the practice.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice is not required to agree to the request. If the practice agrees to my requested restriction, they must follow the restriction(s).

I, _____, acknowledge and agree that Advanced Oral Surgery of Tampa,
and any affiliates or vendor thereof, including collection or billing companies, may contact me by telephone or text message to any tele phonic number I have provided to you, and any other telephone number associated with my account, including wireless or mobile telephone numbers. I further agree that you may use any method of contact to these numbers, such as an Automated Telephone Dialing System (ATDS) or prerecorded message. I also agree that I will notify Advanced Oral Surgery if I have given up ownership or control of any such telephone number.

EMAIL REFERRALS, X-RAYS TO: ADVANCEDOSVALRICO@SECUREDDS.COM