semmel oral + facial surgery

PATIENT REGISTRATION FORM

Name: First_____ MI_____ Last_____ Nickname_____

Sex: M/F **Race:** _____**Date of Birth**: Month _____ Day _____ Year _____ **SSN/ID#:**___

Address: Street _____Apt:_____ City _____State ____ Zip _____

Phone Numbers: Home _____ Mobile _____ Work _____

Email address: _____ **Primary Medical Doctor:** _____

Emergency Contact: _____ **Emergency Contact Phone Number: _____**

General Dentist: _____ **Other Dental Specialist: _____**

Pharmacy: _____ **Pharmacy Location: _____**

Initial _____Dr. Semmel is not a network provider for any medical or dental insurance program (including Medicare and Medicaid). Therefore, we collect payment in full at the time of service. We accept cash, personal checks, Visa, Mastercard, Discover, American Express or debit cards. (A 10% discount is offered for payments over 500.00 ONLY when using cash or cashier's check).

Initial _____Dr. Semmel has opted out of the Medicare program. Medicare will NOT pay for any medical procedures performed by Dr. Semmel. Therefore, Medicare WILL NOT accept any claims from Dr. Semmel or the patient.

Initial _____As a courtesy to our insured patients, we will provide the claim, along with required documentation for you to file directly with your insurance provider. This information will be provided to you via email, allowing you to submit online or by mail. We strive to email you within two (2) weeks of your appointment.

Initial _____You, the patient, are responsible for providing all insurance information. Please provide us with correct spellings, correct dates of birth, and updated demographic information. This includes new ID numbers, as well as subscriber information. When providing dental insurance please provide Insurance carrier, and correct claims address. Our office will generate a claim with the information you provide. Claim form indicates that insurance reimburse policy holder directly.

Initial _____Upon scheduling dental implant surgery, we will collect half of surgical fees as a deposit. Remaining balance will be collected upon check-in the day of surgery.

Cancellation Policy: Please call the office within 48 hours of appointment if you wish to cancel your appointment. There will be a 75.00 fee if a 48 hour notice isn't provided.

Insurance Information & Parent/Guardian Information

Name: First_____ MI_____ Last_____ SSN: _____

Relationship to patient: (please check one): ( )Self ( )Parent ( )Guardian ( )Spouse ( ) Other _____

Address: Street _____ City _____State ____ Zip _____

Phone Number: _____ **Date of Birth**: Month _____ Day _____ Year _____

Insurance Company Name: _____Group Number_____

_____ _____ _____

Patient (Guardian) Signature **Relationship to patient** **Date**