O'Gara Dental Registration and History

Today's Date: _____

Patient Information

Patient Name: _____
Last Name

_____
First Name Middle Initial

_____
Preferred Name

Sex: ❒ M ❒ F

Birthdate: _____

~ ~
Social Security Number

❒ Married ❒ Widowed
❒ Separated ❒ Divorced
❒ Single ❒ Minor
❒ Partnership for _____ years

Address: _____

City: _____

State: _____ Zip: _____

E-mail: _____

PHONE NUMBERS

Home: ( ) _____

Work: ( ) _____ Ext.: _____

Mobile: ( ) _____

Best to reach me at: ❒ Home# ❒ Work# ❒ Mobile#

IN CASE OF EMERGENCY, CONTACT:

Name: _____

Phone Number ( ) _____

Whom may we thank for referring you?

EMPLOYER/OCCUPATION

Occupation: _____

Employer/School: _____

Employer's Address: _____

_____

Employer's Phone: ( ) _____

SPOUSE or MINOR'S PARENT'S INFORMATION

Birthdate: _____

~ ~
Social Security Number

Employer: _____

( )
Phone Number

For Office Use Only:

Financial Agreement and Dental Insurance

Who is financially responsible for this account?
❒ Other _____ ❒ Self ❒ Spouse to Patient ❒ Parent to Patient

INSURANCE

Primary Insurance Co.: _____

Insured's Name: _____

Insured's Birthdate: _____

Group Name: _____

Group #: _____ Insured's SS#: _____

Is patient covered by additional insurance?: ❒ Yes ❒ No

Second Insurance Co.: _____

Insured's Name: _____

Insured's Birthdate: _____

Group Name: _____

Group #: _____ Insured's SS#: _____

CONSENT: This is to certify that I, the undersigned, consent to the performing of dental procedures which may be decided upon to be necessary or advisable. The above-named dentist may use my health care information and may disclose such information to the above-named insurance carrier for purposes of claims administration and evaluation, utilization review and financial audit.

ASSIGNMENT OF BENEFITS: I certify that I, and/or my dependents have insurance coverage with the above mentioned insurance company(ies) and assign directly to Dr. O'Gara 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.

APPOINTMENT POLICY: In this age of fast paced lifestyles and technology, we rarely reach our patients personally, thereby making it impossible to confirm. The ever increasing number of voice-mail and answering machines have made it necessary to set an office policy requiring patients to be responsible for their appointments. All Appointments are confirmed at time of scheduling. We schedule special time for each patient and require a 48 hour advance notice for all changes in appointments, otherwise, a $50.00 fee per scheduled hour will be charged. By signing below, I am agreeing to all above statements.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

PRIVACY PRACTICES DOCUMENTATION: I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

For Office Use Only: Written acknowledgement could not be documented due to:

❒ Personal representative not available to sign
❒ Language, communication, or effects of disability impeded acknowledgement
❒ Emergency care impeded acknowledgement
❒ Patient refused to sign ❒ Other, please specify _____