Carolina Dental Alliance

Patient Registration

First Name: _____ Last Name: _____

Date of Birth: _____ SSN: _____

Mailing Address:

_____

City_____ State _____ Zip_____

Home Phone: _____ Cell Phone: _____

Responsible Party (ONLY COMPLETE IF SOMEONE OTHER THAN PATIENT)

First Name: _____ Last Name_____

Date of Birth: _____ SSN: _____

Mailing Address:_____

Home Phone: _____ Cell Phone: _____

Insurance Information:

Name of Insured: _____

Relationship to Insured: _____

Insured SSN: _____ Insured Date of Birth: _____

Employer:

_____

Please let our Patient Coordinator know if you have secondary coverage

EMAIL ADDRESS: _____

Carolina Dental Alliance

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____
have received a copy of this office's Notice of Privacy Practices.

_____
(Please Print Name)

_____
(Signature)

_____
(Date)

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An Emergency situation prevented us from obtaining the acknowledgement
- ☐ Other (Please Specify)

_____

Carolina Dental Alliance

Consent for Treatment

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 healthcare operations like quality reviews.

I have been informed that I may review the practice's Notice of Privacy Practices before signing this consent.

I understand that this practice has the right to change their privacy practices and 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 also understand that I may revoke this consent at any time by making a request in writing, except for information already used or disclosed.

Signature:_____ Date: _____
(Patient, parent, or legal guardian)

If signed by patient representative, state relationship to patient
_____

Carolina Dental Alliance

Name: _____

Email Address: _____

REFERRED TO THE DENTIST BY:

Newspaper	Facebook
Billboard	Radio
Yellow Pages	TV
Direct Mail	Walk by/Drive by
Google/Bing/ Yahoo Search	Brochure
Doctor	Insurance Company
Dentist	Urgent Care

If referred by friend or family, who do we thank for referring you?

_____

Other _____

Carolina Dental Alliance

Important Information
For Our Patients

Dental Insurance
We will gladly assist you with your dental insurance plan. To help us assist you in determining your maximum benefit, please bring your insurance explanation of benefits booklet and your insurance card to your first visit. Most plans cover only a portion of the dental fee, therefore as a courtesy to our patients we will file your primary insurance for you but we ask that you pay the non-covered balance at the time of service unless prior arrangements have been made. If your insurance company has not paid within 60 days you will be billed for the unpaid balance and payment in full will be expected at this time. We recommend you become directly involved in communication with your insurance company in order to expedite payment.

Payment Options
- We accept All major credit cards, Care Credit, money order, cash, or personal check.
- A convenient interest free payment plan through an outside financial institution.

Appointments
In order to allow the best possible care for our patients, we reserve a specific time just for you and make every effort to see you as scheduled. We appreciate your promptness and your consideration in not changing your scheduled time. However, if you need to change your appointment a 24-hour notice is expected.

Patient Agreement
- I understand that my insurance policy is an agreement between the insurance company and me, therefore I am ultimately responsible for all fees incurred for my dental treatment regardless of payment or denial of my insurance claims by my insurance company.
- I authorize insurance payment directly to Carolina Dental Alliance.
- I authorize the release of necessary information to my insurance company to determine liability for payment and to obtain reimbursement for any claims.
- If this account is assigned to an attorney or collection agency, I agree to be responsible for any attorney fees, collection fees, and court cost incurred.

Signature: _____ **Date:** _____