Orange Coast Dental

1717 Old Tustin Ave
Santa Ana CA 92705
(714) 835-9188

Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

Gender: _____ Family Status: _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____

(Cell):_____

Best time to call: _____

Email: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Whom may we thank for the referral to our office?

Name: _____ Relationship: _____

Emergency Contact

Name: _____ Relationship: _____

Phone Number: _____

Consent for Communications

I grant my permission to Orange Coast Dental to upload and store confidential patient information — including account information, appointment information and clinical information — to the secured computers for Orange Coast Dental. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand Orange Coast Dental and myself are responsible for maintaining the strict confidentiality of any information; and that Orange Coast Dental is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I also understand State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand Orange Coast Dental will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my patient information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that Orange Coast Dental has the right to monitor, retrieve, store, upload and use my patient information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand Orange Coast Dental will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the server on my behalf. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBLITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMAION TRANSMITTED,MOITORED,STORED,UPLOADED OR RECEIVED USING THE SITE OR SERVICES.

I understand Orange Coast Dental WILL NOT SHARE ANY INFORMATION WITH ANY FAMILY OR OTHER PARTY WITHIN YOUR FAMILY/FRIENDS WITHOUT A WRITTEN AUTHORIZATION BY THE PATIENT. IF I WISH TO HAVE STAFF SPEAK TO A THIRD PARTY (THAT IS NOT IN RELATION TO INSURANCE OR REFERRALS) IN REGARDS TO MY INFORMATION I WILL SUBMIT A WRITTEN CONSENT WITH THE OTHER PARTIES INFORMATION FOR APPROVAL OF COMMUNICATION.

☐ I CONSENT TO USE MY INFORMATION IN REFRENCE TO ANY REFERALS OR INSURANCE PURPOSES WITH OTHER DENTAL OFFICES AND INSURANCE COMPANIES IN REFRENCE TO MY TREATMENT AT ORANGE COAST DENTAL _____(INITIALS)

I have read the information above regarding the secured uploading of patient information for Orange Coast Dental, and grant Orange Coast Dental permission to securely upload my patient information to the server.

_____ Date: _____ Relationship to Patient:_____

Signature of patient, parent or guardian

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

As a courtesy to the patients the office attempts to verify dental insurance coverage upon becoming a patient of record, but I understand that it is my responsibility to know my plan coverage, limits, and exclusions. Furthermore understand I am responsible for being aware the non covered benefits such as missing tooth, crown, bridge, denture restorations, bruxism, downgrade limitations for fillings and porcelain crowns, as well as all frequency limits. If my plan changes it is my responsibility to notify the office before treatment is rendered.

All estimates are subject to approval by my dental coverage plan therefore the amount due is subject to change after final explanation of benefits have been paid by my insurance.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home, cellphone, text,email, or at my work to discuss matters related to this form, my treatment, insurance, my account, and my bill. I may withdraw my consent at any time.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____

Signature of guarantor of payment/responsible party