

*Oral Surgery Specialists of Northern Michigan*

MICHAEL J. CUSATIS, DDS

Patient's Name: \_\_\_\_\_ SS#: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Work Address: \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_ Student: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Spouse's Name: \_\_\_\_\_

Who is financially responsible for this account? \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Contact Address: \_\_\_\_\_ Contact Phone: (\_\_\_\_) \_\_\_\_\_

Who Referred you to our office: Dentist  Physician  Yellow Pages  Other  - Who? \_\_\_\_\_

Dentist's Name: \_\_\_\_\_ Physician's Name: \_\_\_\_\_

**IS THERE INSURANCE THAT MAY COVER A PORTION OF THE SERVICE: Yes  No**

**DENTAL**

**PRIMARY COVERAGE:**

Carrier: \_\_\_\_\_

Employer: \_\_\_\_\_

Subscriber: \_\_\_\_\_

Birth date: \_\_\_\_\_

Contract/SS#: \_\_\_\_\_

Group/Policy#: \_\_\_\_\_

Member#: \_\_\_\_\_

**INSURANCE**

**MEDICAL**

**PRIMARY COVERAGE:**

Carrier: \_\_\_\_\_

Employer: \_\_\_\_\_

Subscriber: \_\_\_\_\_

Birth date: \_\_\_\_\_

Contract/SS#: \_\_\_\_\_

Group/Policy#: \_\_\_\_\_

Member#: \_\_\_\_\_

**INSURANCE**

**SECONDARY COVERAGE:**

Carrier: \_\_\_\_\_

Employer: \_\_\_\_\_

Subscriber: \_\_\_\_\_

Birth date: \_\_\_\_\_

Contract/SS#: \_\_\_\_\_

Group/Policy#: \_\_\_\_\_

Member#: \_\_\_\_\_

**SECONDARY COVERAGE:**

Carrier: \_\_\_\_\_

Employer: \_\_\_\_\_

Subscriber: \_\_\_\_\_

Birth date: \_\_\_\_\_

Contract/SS#: \_\_\_\_\_

Group/Policy#: \_\_\_\_\_

Member#: \_\_\_\_\_

**PLEASE NOTE: PAYMENT IS EXPECTED AT THE TIME THE SERVICE IS RENDERED.**

**Any question about your insurance coverage or our office policies should be discussed before your appointment.**

**THANK YOU!**

PLEASE REVIEW AND COMPLETE OTHER SIDE

COMMUNICATION TO YOUR DENTIST or PHYSICIAN

To promote quality and continuity of the patient's overall oral health, this office routinely reports by written correspondence to the referring dentists or physician, indicating that the referral process has been completed and a summary of the services that have been provided. Likewise, a record of any pathology is reported to the referring dentist or physician. Frequently, your dentist or physician will request additional information or copies of any radiographs. If at any time, you desire that we do not contact your dentist or physician, please notify the treating doctor during your visit.

FINANCIAL POLICY – and – “SIGNATURE ON FILE” DESIGNATION

I understand that Oral Surgery Specialists of Northern Michigan is a fee for service office. I am aware that a claim will be filed with my insurance company, on behalf of the patient, for all services rendered that arise from this office visit and related office visits.

I understand that the amount of insurance reimbursement for services provided is based solely upon the contract stipulations established by my employer and the insurance company. I acknowledge that I will be responsible to pay Oral Surgery Specialists of Northern Michigan for any services received that are not fully reimbursed by the insurance company.

In the event the procedure(s) billed to the insurance company are not paid in full, for whatever reason, I agree to settle the account in full with Oral Surgery Specialists of Northern Michigan within ten days of notification of the failure of the insurance company to pay. I understand that a finance charge may be applied to any outstanding balance due.

**I have read or have had read to me, the above policies and by my signature I acknowledge that I agree to abide by them. Moreover, I authorize all benefits be assigned and made payable to Oral Surgery Specialists of Northern Michigan.**

\_\_\_\_\_  
Responsible Party's Signature (Patient, Parent or Guardian if Minor)

\_\_\_\_\_  
Date

Relationship: \_\_\_\_\_

MEDICAL RECORDS RELEASE TO INSURANCE

I authorize the release of all medical information necessary to process the insurance claim.

\_\_\_\_\_  
Responsible Party's Signature (Patient, Parent or Guardian if Minor)

\_\_\_\_\_  
Date

Relationship: \_\_\_\_\_