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 INSURANCE
PRIMARY COVERAGE:
Carrier: _____
Employer: _____
Subscriber: _____
Birth date: _____
Contract/SS#: _____
Group/Policy#:_____
Member#: _____

SECONDARY COVERAGE:
Carrier: _____
Employer: _____
Subscriber: _____
Birth date: _____
Contract/SS#: _____
Group/Policy#:_____
Member#: _____

MEDICAL INSURANCE
PRIMARY 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: _____