Patient Registration

Patient Information

Preferred Name:_____________________

First Name:________________________ **Last Name:**________________________ **Middle Initial:** ___

Date of Birth:_______________ **Social Security#:**_____________________ **Gender:**_______________

Driver's License #:_____________________**Email Address:**___________________________________

Address:_____________________________ **City:**____________________ **State:**____ **Zip:**__________

Cell #: ______________________ **Home #:**______________________**Work #:**____________________

Emergency Contact Information:

Name:__________________________ **Relationship:**______________ **Phone #:**__________________

Dental History

Do you have dental anxiety?

☐Yes ☐No

When was your last dental appointment?

☐Less than 1 year ☐1-2 years ☐5+ years

Responsible Party (If someone other than the patient)

☐ **Primary Insurance Subscriber** ☐ **Guardian/Parent**

First Name:________________________ **Last Name:**________________________ **Middle Initial:** ___

Date of Birth:_________________________ **Social Security#:**_________________________________

Address:____

Insurance Information

Insurance Name:_______________________________ **ID#:**__________________________________

To the best of my knowledge, the questions on this form have been accurately answered.

Patient/Guardian Signature:_______________________________________ **Date:**_______________

MarVista Dental
1205 4th Street Los Osos CA 93402
P: 805.528.1695 F:805.528.1697
marvistadental@hotmail.com

Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Right section describing your rights under the law. You have the right to review our notice before signing this consent form. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office. You also have the right to review the Dental Materials Facts Sheet.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operation. You do have the right to request that we restrict how protected health information about you is disclosed. You have the right to revoke this consent, in writing accompanied by your signature. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations
- The Notice of Privacy Practices and Dental Materials Facts Sheet is available for the patient to review
- The Practice has the right to change the Notice of Privacy Practices
- The patient has the right to restrict the use of their personal health information
- The patient may revoke this consent in writing at any time and all future disclosures will cease

Patient First & Last Name ____

Patient Signature __________________________________ **Date** ________________

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Appointment Policy

Our goal is to provide quality care in a timely manner. In order to do so, we have had to implement an appointment policy. The policy enables us to better utilize available appointments for our patients in need of dental care.

Scheduled Appointments

To schedule an appointment please call (805)-528-1695 between the hours of 8:00am-4:30pm Tuesday through Friday. We encourage you to schedule routine appointments at the time of your most recent cleaning to maintain your oral health. Considering that most routine cleaning appointments are scheduled anywhere between 3 to 6 months in advance, we ask that you confirm your appointment at least 48 business hours in advance. If you do not confirm your appointment after several attempts to reach you from our office, your appointment will be canceled and offered to another patient.

Cancelling an Appointment

In order to be respectful of the needs of other patients, please be courteous and call our office at least **48 business hours in advance** if you are unable to attend the appointment. This time will be reallocated to someone who is in urgent need of treatment. This will help us best observe the needs of all our patients.

Please call our office if this is necessary and leave a detailed message on the voicemail.

No Show Policy

Late cancellations will be considered a “No Show” if they are not cancelled 48 business hours in advance. A failure to present at the time of a scheduled appointment will be recorded in the patients chart as a “No Show”. If you are more than 10 minutes late to your appointment time, it will be considered a “No Show”. ***The first time this occurs, fee of $75 will be billed to the patient.*** After the third occurrence, it will be left to the doctor’s discretion whether or not to issue the patient a discharge letter, dismissing the patient from the practice.

The patient’s signature below indicates that the patient has read and understands the above policy.

Patient Signature ____Date _________________

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Patient Financial Policy

In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial policies of this office. Payment is required for all services at the time they are rendered unless you are in a prepaid plan in which we participate. For those patients, applicable co-payments and deductibles will be collected. We accept payment in the form of cash, check, or credit card. However, before claims are filed, coverage will be pre-verified and you will be asked to pay any unmet deductible, non-covered services, and co-payments. In the event, that your account is **past due 60 days** it will be turned over to our collection agency unless a prior payment has been made and documented with our office. Your signature below signifies your understanding and willingness to comply with this policy.

Patient Signature ____________________________________ Date ________________

Payment Policy

We are considered **out-of -network** with all insurance companies.

Delta Dental PPO/Premier: Delta Dental requires that you pay for your appointment in full at the time of service. We handle your claim submission to them. Delta Dental then sends the reimbursement to you directly.

Other Insurance Plans: Patients who are covered by insurance plans, in which our office are not providers with, will be required to pay your annual deductible if not met and co-payments at time of service.

Cash Patients: Patients who are not covered by any insurance plan will be required to pay 100% of the total bill at the time of service. Cash paying patients will receive a 5% pre-payment discount on total bill if the payment is made before services are rendered.

Patient Signature ____________________________________ Date ________________