P: 541-756-7568
F: 541-756-0760

ABOVE DENTAL

2070 Virginia Avenue
North Bend, OR 97459
abovedental.com

Who may we thank for referring you to us?

_____

Patient Information

Name: _____ Birth Date: ____ /____ /____ SSN: _____

Employer / School: _____ Home Phone: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Cell Phone: _____ Employer / School Phone: _____

Email: _____

Who to Contact in Case of Emergency: _____ Phone: _____

Person Responsible for Payment *(Fill out this section only if different than above)*

Name: _____ Relationship to patient: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Cell Phone: _____

Primary Insurance Information

Name of Insured: _____

Relation to Patient: _____

Birth Date of Subscriber: ___ / ___ / ___

☐ SSN ***OR*** ☐ Insurance ID#: _____

Employer: _____

Secondary Insurance Information

Name of Insured: _____

Relation to Patient: _____

Birth Date of Subscriber: ___ / ___ / ___

☐ SSN ***OR*** ☐ Insurance ID#: _____

Employer: _____

Above Dental accepts payment by cash, check, Care Credit, credit cards (Visa, Mastercard, Discover, American Express), and Health Savings Accounts.

Every patient, please read and initial:

___ I understand that payment is due in full at the time of service unless other arrangements have been made prior to treatment

___ Above Dental offers a 5% "cash" discount for services paid in **full on the date of service**. This discount is only applicable with cash or check (not credit cards or hope of insurance payment).

Patients with insurance, please read and initial:

___ I certify that I, and/or my dependent(s), have insurance coverage and assign directly to Above Dental (Devin Brice, DMD, PC) all insurance benefits, if any, otherwise payable directly to me for services rendered.

___ I understand that I am financially responsible for all charges whether paid or not by insurance.

___ I understand Above Dental (Devin Brice, DMD, PC) tries to determine insurance eligibility, benefits, maximums, coverage amounts, and co-pays, but the ultimate responsibility to verify insurance benefits is with me. Insurance companies have great latitude to deny payment for whatever reason and even to retroactively reclaim money already paid out. I understand this and will pay for whatever my insurance company decides not to pay.

___ I authorize the use of my signature on all insurance submissions.

___ Above Dental (Devin Brice, DMD, PC) may use my health care information and may disclose such information to my insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

I have read and understand the statements I have initialed above:

_____	_____	_____
Patient / Guardian Signature	Printed Name	Date