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?

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Patient Information

Name: ______________________________________ Birth Date: ____ / ____ / ____ SSN: ______________________ ☐ M ☐ F ☐ X

Employer / School: ____ Home Phone: ____________________________________

Mailing Address: ________________________________ City: ______________________ State: _____ Zip: _______________________

Cell Phone: __________________________ Email: ____

Who to Contact in Case of Emergency: ______________________________________ Phone: ____________________________________

We require current and correct information when verifying insurance benefits

☐ ***Without this information, you will be expected to pay in full at time of service.***

Primary Insurance Information

Name of insurance company: ________________________________

Phone number of insurance company: ______________________

Group number: ____

Name of Insured: ____

Relation to Patient: ____

Birth Date of Subscriber: ____ / ____ / ____

☐ SSN ***OR*** ☐ Insurance ID#: ________________________________

Employer: ____

Secondary Insurance Information

Name of insurance company: ________________________________

Phone number of insurance company: ______________________

Group number: ____

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, MC, Discover, AMEX) and HSA's.

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 only applies to a cash or check transaction. Debit or credit card payments do not qualify for a cash discount.

___ I understand that an 18% interest rate will incur after 90 days if my balance has not been paid in full.

___ I understand that Care Credit transfers must be a minimum of $300.

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