

FRANCIS J. CUSUMANO D.D.S., P.A.

ORAL AND MAXILLOFACIAL SURGERY _____ 919.661.1995 • FAX 919.661.1977
DENTAL IMPLANT SURGERY _____ 51 TECHNOLOGY DRIVE • SUITE C • GARNER, NC 27529
fjcoralsurgery@bellsouth.net

Please complete in ink

Patient Information

Full Name	Date of Birth:	Age:
Address	City, State	Zipcode
Home#	Work #	
Mobile#	Other #	
Social Security#	Drivers License#	
Occupation:	Employer:	
Sex: Male or Female	Phone:	
In case of an emergency contact		

How did you hear about us?

Referred by Dentist: (name)	Advertisement:
Recommended by:	Other:

(Mark "Same" if same as above)

Responsible Party

Full Name:	Relationship:
Address	City, State, Zipcode:
Home#:	Work#:

Insurance Policy

Name of insured:	Date of Birth:
Social Security:	Employer:
Insurance Company:	Address:
Policy # Group#	Phone:

Do you have additional dental insurance? Yes No . If yes, please indicate below.

Name of Insured:	Date of Birth:
Social Security :	Employer:
Insurance Company:	Address:
Policy# Group #	Phone:

Signature of Patient or Responsible Party



Date

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WELCOME

We are pleased to welcome you to our practice of Oral and Maxillofacial Surgery. New patients are always appreciated. Our practice is growing as a result of our excellent relationship with our referring doctors and patients. Please feel free, at any time, to express any concerns or ask any questions that you may have for our doctors and staff. To facilitate your payment arrangements the following options are listed. Please read them carefully, initial and sign all designated lines.

FINANCIAL POLICY / PAYMENT OPTIONS

IF YOU DO NOT HAVE INSURANCE, payment is due in full at the time the treatment is provided. For your convenience, financing is available upon credit approval. Please inquire with one of our patient representatives for details. We gladly accept MasterCard and Visa. _____(Initial)

IF YOU HAVE INSURANCE, we are happy to assist you in submitting your insurance claim to your insurance carrier. You are responsible, at the time of your appointment, for any deductible or co-payment not covered by the insurance company. Preauthorization may be required by your insurance provider and is not a guarantee of payment. For procedures, one half (1/2) of the total amount will be due the day of procedures. Co-payments are accepted for procedures if written authorization from your insurance carrier is on file. You are responsible for filing medical insurance claims except in certain situations. You are responsible for any account balances. Failure of your insurance carrier to reimburse your account within 60 days will result in our office billing you directly for the balance. If your account has a credit, a reimbursement check will be issued to you. _____(Initial)

It is your responsibility to check with your insurance company and make sure you do not need a second opinion and to check for pre-certification requirements. _____(Initial)

I am aware that I am responsible for charges incurred on this account. _____(Initial))

INSURANCE PATIENTS – PLEASE READ CAREFULLY: The amount of coverage paid by your insurance company may be based on your insurance company's own reduced fee schedule for Oral and Maxillofacial Surgical services and may be less than actual charges resulting in lower coverage for you. We have no control over this situation. Lower payment/reimbursement is a direct result of the plan selected by you or your employer. We cannot waive co-payments and you will be responsible for any unpaid balance. _____(Initial)

PATIENTS REQUIRING HOSPITALIZATION: The fees quoted to you represent the fees of our surgeons only. You will receive a bill from the hospital and possibly other medical providers.

PLEASE NOTE: There will be a \$25.00 fee for returned checks. _____(Initial)

Regarding HIPPA: We are required by federal and state law to maintain the privacy of your health information. We are also required to give you information about our privacy practices. By signing below you are acknowledging you have received a copy of the HIPPA privacy handout

Print Name of Responsible Party

Print Name of Patient

Signature of Responsible Party

Date



Member
American Association of Oral and
Maxillofacial Surgeons