CAROLINA FAMILY ORTHODONTICS

Adult NP

Today's Date _____/_____/_____.

Name (Mr Mrs Ms Dr) _____
Last First MI

I prefer to be called _____

Birthdate _____/_____/_____.

Home Address _____ Email Address _____

City _____ State _____ ZIP _____ (for appointment reminders only)

Home # (_____) _____ Cell/other # (_____) _____

Responsible Party Information

Name: _____ Marital Status _____

Address _____

City _____ State _____ ZIP _____

Home # (_____) _____ Cell/other # (_____) _____

Date of Birth _____ Social Security # _____ Relation to patient_____

Email Address (for appointment reminders) _____

Insurance Information

Insured's Name _____Insured's Soc. Sec. # _____

Insurance Company _____Group No. _____ID #_____

Insured's Employer_____Insured's Birthdate_____

Do you have dual coverage? Yes No If yes, please fill out below:

Insured's Name _____Insured's Soc. Sec. # _____

Insurance Company _____Group No. _____ID #_____

Insured's Employer_____Insured's Birthdate_____

Insurance Assignment and Release - I, the undersigned assign directly to Carolina Family Orthodontics all insurance benefits, otherwise payable to me for the services rendered. I also hereby authorize Carolina Family Orthodontics to release all information necessary to secure the payment of benefits. I authorize the use of the signature on all insurance submissions.

Financial Responsibility - I understand that I am financially responsible for all charges whether or not paid by insurance or the responsible party. I am aware of the financial policies regarding patient services, payment, and insurance assignment.

In accordance with the federal government HIPPA rules, please sign below to acknowledge you have received our Notice Of Privacy Practices; it will in no way affect the care you receive at Carolina Family Orthodontics.

I consent to the taking of x-rays, models and photographs necessary for diagnostic purposes.

_____ _____
Signature (parent or guardian if patient is a minor) Date