RICK LACUESTA, D.D.S.
PRACTICE LIMITED TO PERIODONTICS AND DENTAL IMPLANTS
22-29TH STREET
GULFPORT, MISSISSIPPI 39507
228/868-9615

Personal Information

Patient's Name (Mr / Mrs / Ms) _____

Mailing Address _____
Street/P. O. Box City State Zip

Date of Birth _____ Male ____ Female ____ Social Security # _____

Single ____ Married ____ Divorced ____ Widowed ____ Minor ____ Age ____ Weight _____

Employer _____ Phone # / Dept. _____

Spouse's Name _____ Soc. Sec. # _____

Date of Birth _____ Employer / Phone # / Dept. _____

Referring Dentist _____ Physician _____

Telephone Information

Home Phone _____ Work Phone _____ Cell _____

E-Mail Address _____

In the event of an emergency, whom should we contact? _____

Name _____ Relationship _____ Phone _____

Responsible Party

Who is responsible for the account? _____

Address/City/State/Zip _____

Relationship to patient _____ Soc. Sec. # _____ Date of Birth _____

Employer _____

Work Phone _____ Home Phone _____

Insurance Information

Primary Insurance

Name Of Insurance _____

Policy Holder _____

Relation to Patient _____

Insured's Birth Date _____

Social Security # _____

Group Number _____

Employer _____

Secondary Insurance

Name Of Insurance _____

Policy Holder _____

Relation to Patient _____

Insured's Birth Date _____

Social Security # _____

Group Number _____

Employer _____

NOTICE: We file insurance as a courtesy to our patients. You are fully responsible for payment of your account regardless of the status of your insurance.

Financial/Insurance Agreement

PLEASE READ CAREFULLY

Financial Arrangements

PAYMENT OR CO-PAYMENT (IF INSURANCE APPLIES) IS DUE IN FULL AT TIME OF VISIT UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE. For your convenience, we offer the following methods of payment.

(Please check which method you prefer) Cash__ Personal Check__ Credit Card__ MC__ Visa__ Discover__ American Express__

INSURANCE:

Insurance forms will be filed as a courtesy to our patients. You are fully responsible for payment of your account regardless of the status of your insurance. This office does not accept the responsibility of collection or negotiating a settlement of a disputed claim. If this office receives overpayment from your insurance company, it will be reimbursed promptly. If your insurance company takes longer than six (6) weeks to pay, we would expect that you make a payment on the account and also contact your insurance company to find out the status of your claim. You are fully responsible for any amount they do not pay. If regular payments have not been paid within 90 days, your account will be turned over to a collection agency and/or taken to court. You will be fully responsible for any cost incurred in the collection of your account.

CANCELLATION/BROKEN APPOINTMENTS:

If you must cancel your scheduled appointment please give us 24 hours (48 hours for surgery) notice. Failure to do so will result in charges, according to the type of appointment scheduled.

AUTHORIZATION AND RELEASE:

I authorize the release of any information, including the diagnosis and records of any treatment or examination rendered to me or my child during the period of such care, to third party payors and/or other health practitioners.

I authorize and request my insurance company to pay directly to the health care provider, insurance benefits otherwise payable to me.

I understand that my insurance carrier may pay less than the actual bill for the services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature: _____ Date: _____

Privacy Policy Consent

I give this practice/clinic my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations like quality reviews.

I have been informed that I may review the practice/clinic's Notice of Privacy Practices (for a more complete description of uses and disclosures) before signing the consent.

I understand that this practice/clinic has the right to change their privacy practices and that I may obtain any revised notices at the practice/clinic.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice/clinic is not required to agree to the request. If the practice/clinic agrees to my requested restriction, they must follow the restriction(s).

I also understand that I may revoke this consent at any time, by making a request in writing, except for information already used or disclosed.

Signature: _____Date:_____

Patient, Parent or Legal Guardian

If signed by patient representative, state relationship to patient: _____

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22-29th Street
Gulfport, MS 39507
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April 2, 2008

Fee Payment

We make every effort to keep down the cost of your dental care. It is customary for our patients to pay for services as rendered. If your treatment program requires multiple visits, you will be given an estimate, and if needed, a suitable payment plan can be arranged. After 90 days, any unpaid balance will accrue at 1.5% finance charge each month.

_____ _____

Patients/Responsible Party Signature Date