Jonathan K. Nakano, D.M.D
Oral & Maxillofacial Surgery

PATIENT INFORMATION

Patient Name_____Birthdate_____Age_____
Marital Status _____ Email Address _____
Address_____City_____ State____Zip_____
Home Phone_____Work Phone_____Cell Phone_____
Social Security #_____Employer_____
Student: yes no School_____ full time or part time
Dentist_____ Orthodontist_____
Physician_____ Referred by_____
In case of emergency_____ Phone # _____

RESPONSIBLE PARTY'S BILLING INFORMATION *(IF DIFFERENT FROM PATIENT)*

Person Responsible for Account_____Birthdate_____
Address_____ City_____ State_____ Zip_____
Home Phone_____Work Phone_____Cell Phone_____
Email _____
Social Security #_____Employer_____
Employer phone number _____

Spouse's Name_____Birthdate_____
Home Phone_____Work Phone_____Cell Phone_____
Email _____
Social Security #_____Employer_____
Employer phone number _____

PRIMARY INSURANCE Dental___ Medical___

Insurance Company_____Group#_____
Subscriber's Name_____Birthdate_____
Social Security # OR Member ID # _____
Employer_____ Relation to patient _____

SECONDARY INSURANCE Dental___ Medical___

Insurance Company_____Group#_____
Subscriber's Name_____Birthdate_____
Social Security # OR Member ID # _____
Employer_____ Relation to patient _____

(over)

Jonathan K. Nakano, D.M.D.

Oral & Maxillofacial Surgery Implantology Corrective Jaw Surgery Extractions

FINANCIAL POLICY

Welcome to our office. We are proud to be a team of health care professionals whose goal is to provide you with the highest quality and most cost effective care possible. We are also aware that unexpected health care costs can significantly impact your budget and we want to make our services as affordable as possible. In order to assist you with your health care investment, we provide the following payment options and ask that you read the following information.

The patient (or parent/legal guardian, if patient is a minor child) is responsible for payment in full at the time our services are rendered. Acceptable forms of payment for these services are CASH, PERSONAL CHECK, MASTERCARD, VISA, DISCOVER, AMERICAN EXPRESS OR CARE CREDIT.
WE DO NOT CARRY ACCOUNTS IN OUR OFFICE.

INSURANCE

We will gladly estimate your portion of treatment costs, and bill your insurance company for your treatment fees, all at no extra cost to you. The estimated amount not covered by your insurance company is due at the time the treatment is rendered. Our estimates are subject to final approval by your insurance company. Therefore, your exact portion of treatment costs cannot be determined until we have received the final payment from your insurance company. If you have a balance remaining after the insurance pays, you will be sent a final statement at that time.

PRE-AUTHORIZATION OF INSURANCE BENEFITS

Pre-authorization of insurance benefits may be in your best interest. Many patients are uncertain if recommended treatment is covered by their insurance plan, or at what percentage the insurance may pay for covered benefits. In some cases, insurance companies do require pre-authorization for any treatment that will be over a certain dollar amount, or certain types of treatment. In these situations, we will be happy to send the required information to your insurance company for pre-authorization consideration. This process normally takes 4 to 6 weeks for insurance companies to process the paperwork and get it back to us. Emergency treatment is normally excluded from this pre-authorization process.

Please understand that our professional services are provided to the patient, and not to the patient's insurance company. THE PATIENT IS ULTIMATELY RESPONSIBLE FOR PAYMENT, AND THE INSURANCE COMPANY IS ONLY RESPONSIBLE TO THE PATIENT. We will do the initial billing to your insurance company, but it is the responsibility of the patient to see that the insurance company pays on their claim. We will try to make this process as simple for you as your insurance company allows.

CANCELLATION POLICY

PATIENTS THAT FAIL TO SHOW OR CANCEL THEIR SCHEDULED SURGERY WITHOUT 24 HOURS NOTICE MAY BE CHARGED A $50 CANCELLATION FEE.

_____ _____

Signature of Patient/Parent or Legal Guardian **Today's Date**

61 Long Court, Suite 101 Thousand Oaks, CA 91362
Phone: 805-496-0112 Fax: 805-496-1141

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HIPPA ACKNOWLEDGEMENT

I have received the Notice of HIPPA Privacy Practices, and I have been provided the opportunity to review it.

_____
Patient Name

_____
Patient Signature

_____
Patient's Birthdate

_____
Date

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