EDISTO ORAL SURGERY

Eric Olendorf, DDS • Board-Certified Oral Surgeon

1175 Cook Road, Suite 125
Orangeburg, SC 29118
p: (803) 534-5444 f: (803) 531-3668

NEW PATIENT REGISTRATION

Please complete all sections thoroughly and accurately. This information helps us provide safe and efficient surgical care.

Date: _____

PATIENT INFORMATION

First Name: _____ M.I.: _____ Last Name: _____

Birth Date (MM/DD/YY): _____ Gender: ☐ Male ☐ Female

Address: _____

City: _____ State: _____ ZIP: _____

Email: _____ Cell Phone: _____

Social Security #: _____ Driver's License #: _____

General Dentist: _____ Referring Doctor: _____

Pharmacy: _____ Pharmacy Address: _____

Emergency Contact: *(Not living with you)* _____ Phone: _____

WHO WILL BE RESPONSIBLE FOR YOUR ACCOUNT

☐ Self (skip this section) ☐ Spouse ☐ Father ☐ Mother Other: _____

First Name: *(Must be present today)* _____ Last Name: _____

Email: _____ Driver's License #: _____

Birth Date (MM/DD/YY): _____ S.S. #: _____

DENTAL INSURANCE INFORMATION

Name of Primary Dental Insurance: _____

Policy Holder Name: _____ Birth Date: _____

Member ID: _____ Group #: _____

Name of Employer: _____

Relationship to Policy Holder: ☐ Self ☐ Parent ☐ Child ☐ Spouse Other: _____

MEDICAL INSURANCE INFORMATION

Name of Primary Health Insurance: _____

Policy Holder Name: _____ Birth Date: _____

Member ID: _____ Group #: _____

Relationship to Policy Holder: ☐ Self ☐ Parent ☐ Child ☐ Spouse Other: _____

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Patient Name: _____ Date: _____

FEES & PAYMENTS

We make every effort to keep down the cost of your care. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the surgeon and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance. You will be responsible for all collection costs, attorney's fees, and court costs.

MEDICARE NOTICE (NON-PARTICIPATION)

Our providers have chosen not to be participating providers with Medicare. As such:

- We cannot file Medicare claims on your behalf.
- You may not submit claims to Medicare for services provided in this office.
- You will be responsible for payment in full at the time of service.
- You will accept full financial responsibility for services rendered.

HIPAA NOTICE (AUTHORIZATION TO RELEASE INFORMATION)

We are committed to protecting your privacy. We do not release your medical or personal information outside of your provider and insurance networks without written permission.

If you would like us to share your appointment details or health information with others, please list them below:

Authorized Individual(s):

1. Name: _____ Relationship: _____
2. Name: _____ Relationship: _____

I hereby acknowledge that I have read, understood, and been offered a copy of (or access to) the above policies and notices, including the Notice of Privacy Practices (HIPAA), Fees & Payments Policy, and Medicare Notice (Non-Participation). I understand these policies have been explained to me and I have had the opportunity to ask questions regarding their contents. I further certify that the information I have provided is true and accurate to the best of my knowledge.

_____ _____

Patient / Guardian Signature Date