STEVENSHIMAMOTO, DMD

PATIENT DEMOGRAPHIC FORM

(This form is to be updated yearly or with any information changes)

PATIENT INFORMATION

Patient Full Name: _____ Patient's SSN: _____-_____-_____

Date of Birth: _____ Sex: M_____ F _____ Marital Status S M D W

Street Address: _____ Apt. #: _____

City: _____ State: _____ Zip Code: _____

Home Phone: ( ) _____ Work Phone: ( ) _____

Cell/Pager: ( ) _____ Email Address: _____

Employer: _____ Emergency Contact Name: _____

Emergency Contact Number: ( ) _____ Relationship to Patient: _____

How did you hear about us? _____

GUARANTOR/PARENT INFORMATION (If different from above)

Responsible Party Name: _____ Guarantor's SSN: _____-_____-_____

Relationship to Patient: _____ Responsible Party Date of Birth: _____

Guarantor's Address: _____ Apt. #: _____

City: _____ State: _____ Zip Code: _____

Home Phone: ( ) _____ Cell/Pager Number: ( ) _____

Employer's Name: _____ Work Phone: ( ) _____

Employer's Address: _____

City: _____ State: _____ Zip Code: _____

PATIENT'S INSURANCE INFORMATION *Please provide Insurance Card and Photo ID to Receptionist*

Primary Insurance Company Name: _____

Insurance Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: ( ) _____ Policy Holder's SSN: _____-_____-_____

Name of Policy Holder: _____ Date of Birth: _____

Insurance ID Number: _____ Group Number: _____

Secondary Insurance Company Name: _____

Insurance Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: ( ) _____ Policy Holder's SSN: _____-_____-_____

Name of Policy Holder: _____ Date of Birth: _____

Insurance ID Number: _____ Group Number: _____

I herby authorize my insurance benefits to be paid directly to Steven Shimamoto DMD PC. I understand and am responsible for all charges including my added costs incurred due any effort to collect for services rendered. I realize I am responsible to pay for non-covered services and I hereby authorize the release of pertinent medical information to insurance carriers.

Signature of Responsible Party: _____ Date: _____

IMPORTANT OFFICE POLICIES -

Release of Medical Information

I authorize Steve Shimamoto DMD PC to release the medical records concerning my son/daughter/self to any physician, hospital, or agency involved in the care of the patient listed.

Payment Policy

Co-payments are to be collected at the time services are received. We accept cash, checks, Visa and MasterCard. All medical services provided are directly charged to the patient or responsible party. You will be responsible for any balance deemed patient responsibility/non-payable/non-covered by your insurance and billed accordingly. Payment is expected in full upon receipt of statement or payment arrangements must be made with our billing office.

Cancellation Policy

We value your time and set aside an allotted amount of time for you upon scheduling an appointment. Please arrive at your scheduled appointment time. If you are running late, please contact our office so we can plan accordingly. When you need to cancel, please let us know as soon as you can.

HIPPA (Health Insurance Portability and Accountability) Policy

_____ I acknowledge I have received a copy of Dr. Shimamoto's Notice of Privacy Practices.

I HAVE READ, UNDERSTAND, AND AGREE TO ABIDE BY THE ABOVE RELEASE OF MEDICAL INFORMATION, PAYMENT AND OTHER OFFICE POLICIES.

Signature of Responsible Party: _____ Date: _____