**Jerrold A. Hiura, DDS**

**Stephani D. Ueno, DMD**

**90 E. Taylor St. San Jose, Ca. 95112**

**(408) 294-9944**

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**CONFIDENTIAL**

First Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle Initial \_\_\_\_

Preferred Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Male \_\_\_ Female \_\_\_\_

Birth date: \_\_­­\_/\_\_\_/\_\_\_\_ Soc Sec # \_\_\_\_\_-\_\_\_\_-\_\_\_\_\_ Driver’s Lic: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_\_\_

Address (**NO P.O. Box**) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_Apt #\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State \_\_\_\_\_\_\_\_\_\_\_\_\_Zip Code \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone (\_\_\_) \_\_\_-\_\_\_­\_\_ Work Phone (\_\_\_) \_\_\_-\_\_\_\_­\_ Extension\_\_­­\_\_\_\_ Cell Phone (\_\_\_)\_\_\_-\_\_\_\_\_

E-mail:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I’d like email correspondences I’d like to receive text messages

**Mailing address if different from above**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Apt # \_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State \_\_\_\_\_\_Zip Code \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_\_\_\_

Student Status: Full Time ( ) Part Time ( ) School Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Check Appropriate Line: Married \_\_\_ Single \_\_\_ Divorced \_\_\_\_ Separated \_\_\_\_ Widowed\_\_\_\_\_

Spouse’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Whom may we thank for referring you to our practice? Friend Relative Yellow Pages YELP Other \_\_\_\_\_

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Information**

Name of nearest relative not living with you \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone (\_\_\_) \_\_\_\_-\_\_\_\_\_\_\_\_

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| **Financially Responsible Party Information** |

Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient: Self \_\_\_\_ Husband \_\_\_\_Wife \_\_\_\_Father \_\_\_\_ Mother \_\_\_\_Other\_\_\_\_

(IF OTHER THAN SELF PLEASE COMPLETE THE FOLLOWING PAGE)

Preferred method of payment: Cash or Check \_\_\_\_ Credit Card \_\_\_\_ Alternative billing source (ask) \_\_\_\_

Automatic Credit Card Payments:

\_\_\_ Charge my credit card at each visit

\_\_\_ Charge my credit card any outstanding balance after insurance has paid

\_\_\_ \* My insurance pays me, charge my credit card account balance

Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Exp \_\_\_\_\_\_\_\_ 3 digit code \_\_\_ Visa\_\_ MC\_\_

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FINANCIALLY RESPONSIBLE PARTY** (other than self):

First Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle Initial \_\_\_\_

Birth date: \_\_\_/\_\_\_/\_\_\_\_\_ Soc Sec # \_\_\_\_-\_\_\_-\_\_\_\_\_ Drivers Lic: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_

Address (**NO P.O. Box**) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ Apt #\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State \_\_\_\_ Zip Code \_\_\_\_\_\_\_\_\_\_

**Mailing address if different from above**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Apt # \_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State \_\_\_\_ Zip Code \_\_\_\_\_\_\_\_\_\_

Home Phone (\_\_\_) \_\_\_-\_\_\_\_ Work Phone (\_\_\_) \_\_\_-\_\_\_\_ Extension\_\_\_\_\_ Cell Phone (\_\_\_) \_\_\_-\_\_\_\_

E-mail:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_\_\_

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| **Dental Insurance Information** |

\_\_ I am not covered by any Dental Insurance

**PRIMARY INSURANCE SUBSCRIBER**

Subscriber Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ SS# \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Insurance ID# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Company Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Phone # (\_\_\_\_) \_\_\_\_-\_\_\_\_\_ Amount used this benefit year \_\_\_\_\_\_\_\_

**SECONDARY INSURANCE SUBSCRIBER**

Subscriber Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ SS# \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Insurance ID# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Company Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Phone # (\_\_\_\_) \_\_\_\_-\_\_\_\_\_ Amount used this benefit year \_\_\_\_\_\_\_\_

***Your insurance policy is a contract between you and your insurance company. It is the patient’s responsibility to know their particular plan. Please give us the most updated and accurate insurance information so that we may do our best to give you the correct estimate. There may be a $50 reprocessing fee should any insurance information be incorrect. We will gladly submit your insurance claims for you but you are personally responsible for your account balance should your insurance fail to pay. Please notify our office of changes in the insurance carrier or policy within 30 days of change.***

**I acknowledge the above, I agree to the terms, and I am responsible for all treatment fees for services performed on myself and my family.**

**Signature of Responsible Party: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_**

**OFFICE POLICIES**

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| **APPOINTMENTS** |

* We request that you give **48 hour** notice if you must cancel or reschedule. There is a $50.00 charge for missed or late canceled appointment. This fee is not covered by insurance.

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| **FINANCIALS** |

* **Payment is expected at time of service**
* Cosmetic, major restorative, implant services and Invisalign are subject to 50% prepayment.
* **Insurance**: **Copayments and** **deductibles are due when services are rendered**. Your insurance policy is a contract between you and your insurance company. It is difficult to predict what the insurance company will pay and it is the patient’s responsibility to know their particular plan. We will gladly submit your insurance claims for you but you are personally responsible for your account balance should your insurance fail to pay. There may be a $50 reprocessing fee should any insurance information be incorrect. Please notify our office of changes in the insurance carrier or policy within 30 days of change.
* Payment plan: third party financing may be arranged through Care Credit for no interest payment plans. **All arrangements must be made in advance.** Please see financial coordinator for more information.
* We accept cash, debit, Visa, Mastercard, Flexcard, checks and money orders. There is a $20.00 fee for returned checks.
* Prior arrangements can be made with our financial coordinator.
* We reserve the right to charge interest for due balances over 90 days.

Authorization, Release & Agreement to Pay for Services Rendered

* I authorize the dentist to release any information including the diagnosis and the record of any treatment or examination rendered to me during the period of such dental care to third party payers and/or health practitioners.
* I have received the HIPAA (Health Insurance Portability and Accountability Act) and Dental Materials Fact Sheet. (Pages 6 & 7)
* I authorize and hereby request my insurance company to pay directly to the dentist (or the dental group) insurance benefits otherwise payable to me.
* I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents.
* I understand that where appropriate, a Credit Bureau report may be obtained.

**Signature of Patient, Parent or Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_\_\_\_\_\_\_\_**