

Thank you for choosing Kona Coast Dental Care for your dental needs. We are committed to providing you with excellent care, unprecedented convenience, and affordable financial options. Our financial arrangements are based on an open and honest discussion of recommended treatment options, respective fees and patients' financial capabilities.

To confirm your understanding and agreement with our policies, please read and sign the following.

## Payment:

Payment is due in full when scheduling dental treatment. For your convenience we offer several payment options.

- Cash, Visa, MasterCard, American Express, and Discover
- Checks
- Extended payment plans provided through Care Credit and other finance companies

## Insurance:

Our office is committed to helping patients maximize their benefits, however insurance policies vary greatly. Therefore, we can only ESTIMATE in good faith, not guarantee payment or coverage from your insurance carrier. Any and all estimated out-of –pocket expenses will be discussed in detail before starting any dental procedures.

## Financial Consent:

The patient or guardian agrees to be fully responsible for total payment of treatment performed in this office regardless of reimbursement from Insurance carrier.

I understand and agree to this Financial Policy and Agreement. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Kona Coast Dental Care and their Associate Doctors to release any information required to process my claims.

Name of Patient (Please Print)	Name of Responsible Party (Please Print)
Signature of Responsible Party	<b>Date</b>



## PATIENT REGISTRATION FORM

Today's Date:									
			PATIEN	T INFORM	MATION				
Last Name:		First:		Middle:		Preferred Name:			
□Mr. □Mrs. Marital St	ratus (please circle one)	)		Birth Date:		Social Security Number:			
Ms. Single / Married / Other:				/					
Email Address:				<u> </u>		<del>-</del>	Cell Phone Number:		
Ziiwii i Iuuli voo.					( )				
Address:	City:			State:	Zip code: Home Phone Number:				
Occupation:	Employer:				Employer Phone Number:				
Chose clinic because/Referred	heck one box):					☐ Insurance Plan	☐ Hospital		
☐ Family	☐ Friend	☐ Close to home/work	☐ Yello	ow Pages	□ Other				
Other family members seen h	ere:								
Medical History Women Only:									
Are you under a physician's of Have you ever been hospitali		o N ration? o N		Yes Yes	Are y	you Pregnant			
Have you ever had a serious l		o N		Yes			et Pregnant		
Do you have sleep apnea? Do you use tobacco?		o N o N		Yes Yes		Nursing	1 Contraceptives?		
List Medications:		O IN	0 0	105		Taking Ora	ir Contraceptives!		
Are you allergic to any of the o Aspirin o Penicillin o		s o Metal o La	tev o	Local Ane	sthetics o Othe	ar.			
o Aspiriii o Teineiniii (	Codelle o Acrylle	o Metal o La	ica o	Local Alle	stricties o othe			_	
Do you have, or have	vou had, any of the	e following?							
o AIDS/HIV Positive				o Headaches			o Scarlet Fev	ver	
o Alzheimer's Disease		Epilepsy or Seizures			o Heart Condit		o Shingles		
o Arthritis/Gout		Excessive Thirst			o Kidney Prob		o Stomach/Intestinal Disease		
o Artificial Joint o Asthma		Sainting Spells/Dizzi	ness		o Liver Diseas		o Sinus Trou		
o Cancer		Glaucoma Hemophilia			o Lung Diseas o Pain in Jaw J		o Tumor or Growths o Parathyroid / Thyroid Disease		
o Cold Sores/Fever Blist		Hepatitis			o Psychiatric C		o Taramyroid / Thyroid Disease		
o Diabetes		o High or Low Blood Pressure o Stroke							
Have you ever had any	serious illness not list	ed above? o Yes o	) No	o N/A					
In case of Emergency	<u>:</u>								
Name of Local Friend or I	Relative (not living ins	ame address):	Relat	ionship To	Patient:	Good Phone N	umber:		
						( )			
The above information is						()			
Patient / Guardian Signat	ure:				Date:				
HIPAA Information and									
I acknowledge that I have questions about it and un- agree to these policies an	derstand that I may rec								