

*D. Jack Fong, D.D.S.*  
amarillo craniofacial pain diagnostic center

Date \_\_\_\_\_

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address/City/State/Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ Email \_\_\_\_\_

Driver's License # \_\_\_\_\_ Social Security # \_\_\_\_\_

Patient's Employer \_\_\_\_\_

Employer Address/City/State/Zip \_\_\_\_\_

Sex: M F Martial Status: Single Married Widowed Divorced

Name of Responsible Party \_\_\_\_\_

Address/City/State/Zip of Responsible Party \_\_\_\_\_

Responsible Party's Employer \_\_\_\_\_

Responsible Party's Employer Address \_\_\_\_\_

Responsible Party's Employer Phone \_\_\_\_\_

Responsible Party's Social Security # \_\_\_\_\_

Name of Spouse \_\_\_\_\_ Date of Birth \_\_\_\_\_

Spouse's Social Security # \_\_\_\_\_

When was the last time you were treated by a dentist? \_\_\_\_\_

How did you hear of our office? \_\_\_\_\_

\*\*\*\*STATEMENT\*\*\*\*

I authorize Dr. D. Jack Fong and Staff to render dental services, medications, and therapy needed and to employ such assistance, as he deems necessary. Furthermore, I will be responsible for the costs of the professional services rendered. I will be responsible for any collector's fees and/or attorney's fees in the event I default on any balance on my account.

\_\_\_\_\_  
Signature of Patient or Responsible Party

**Please continue to next page.**

## ABOUT FINANCIAL ARRANGEMENTS AND INSURANCE

We are committed to providing you with the best possible care. If you have dental or medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

Payment for service is due at the time services are rendered. We accept cash, checks, Mastercard, Visa, American Express, and Discover. We will be happy to help you process your insurance claim form for your reimbursement. In order to process a claim form, please complete the insurance information section on the next page. Returned checks and balances older than 30 days may be subject to additional collection fees. Charges may also be made for broken appointments and appointments canceled without 36 hours advance notice.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. However, you must realize the following:

1. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.
2. Our fees are generally considered to fall within the acceptable range by most companies and therefore are covered up to the maximum allowable range by most companies. This applies only to companies who pay a percentage (such as 50%, or 80%) of "U.C.R." (is defined as usually, customary, and reasonable fees for this region). Thus, our fees are considered usual, customary and reasonable by most companies. This statement does not apply to companies who reimburse based on an arbitrary "schedule" of fees, which bears no relationship to the current standard and cost of care in this area.
3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

We must emphasize that as dental care providers, our relationship is with you, not your insurance company. Our office deals with numerous insurance companies, therefore, we encourage you to read your insurance policy carefully and be familiar with your individual coverage. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above information or any uncertainty regarding insurance coverage, PLEASE don't hesitate to ask us. We are here to help you.

I have read the above information and agree to be financially responsible for my account. I certify that all information on my registration form is true and complete. I authorize Dr. D. J. Fong, Inc. and his staff to retain property of this information, to rely on the foregoing to check and verify my credit, employment history, to secure follow-up credit reports concerning my credit worthiness and to exchange information about my account with proper persons, creditors, and credit bureaus.

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Signature of Patient or Responsible Party

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Date

**Please continue to next page if you have dental insurance.**

## Dental Insurance Information

### Primary Carrier:

Insured's Name \_\_\_\_\_ Employer \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Insurance ID \_\_\_\_\_  
Group # \_\_\_\_\_  
Insurance Address/City/State/Zip \_\_\_\_\_  
Insurance Company Phone \_\_\_\_\_

### Secondary Carrier:

Insured's Name \_\_\_\_\_ Employer \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Insurance ID \_\_\_\_\_  
Group # \_\_\_\_\_  
Insurance Address/City/State/Zip \_\_\_\_\_  
Insurance Company Phone \_\_\_\_\_

### \*\*\*\*Insurance Statement\*\*\*\*

We are not members of any fee schedules other than those fees agreed to between you and this office. When you receive treatment in this office, you agree to be financially responsible for the entire fee in this office, independent of insurance coverage. Again, we will be happy to provide your insurance company with any information they may need. However, it will be your responsibility to pursue payment from the insurance carrier if payment is not received promptly.

\_\_\_\_\_  
I authorize payment of benefits directly to the provider.

\_\_\_\_\_  
Date

\_\_\_\_\_  
I authorize the release of all necessary information to the insurance carrier and their representatives.

\_\_\_\_\_  
Date