MARIO ROYBAL

Mario Roybal
1867 Popps Ferry Road
Biloxi, MS 39532
228-388-4519
dentistinbiloxims.com

New Patient Form

Please fill out all the information to the best of your knowledge. All answers will be kept confidential. If you have any questions, please ask us, and we'll be happy to assist you.	Date: / /	Patient #:

Patient Information

Title:	First Name:	Middle Name:	Last Name:	I prefer to be called:

Sex:	Age:	Date of Birth (mm/dd/yyyy): / /	Marital Status:	Social Security #: - -	Driver's Licence State & #:

Home Phone: - -	Work Phone: - -	Cell Phone: - -	E-mail Address:

Home Address:	City:	State:	ZIP Code:

Employment:	Employer's Name:	Employer's Phone: - -	Occupation:

Employer's Address:	City:	State:	ZIP Code:

Student Status:	School Name (if a full-time student):	Grade:

Best places and times to contact you:	Send appointment reminders via: ❑ Text Message ❑ Email ❑ Mail

Please tell us where you heard about us (check all that apply):

❑ Friend or Relative (name): ❑ Newspaper Ad ❑ Radio Ad ❑ TV Ad
❑ Ad in Mail ❑ Saw our Office ❑ Insurance Company ❑ Our Website
❑ Search Engine (Google, etc.) ❑ Other Website:
❑ Other:

Was our website a factor in your decision to visit our practice? ❍ Yes ❍ No

Name of Spouse (or Parent, if a minor):	Spouse/Parent's Employer:	Spouse/Parent Work Phone: - -	Spouse/Parent Cell Phone: - -

Other family members treated by us:	Additional Comments:

MARIO ROYBAL

Mario Roybal
1867 Popps Ferry Road
Biloxi, MS 39532
228-388-4519
dentistinbiloxims.com

Emergency Contact

This should be the nearest relative who does not live with the patient.

Title:	First Name:	Last Name:	Relationship to Patient:

Home Phone:	Work Phone:	Cell Phone:	E-mail Address:
- -	- -	- -	

Emergency_Contact Address:	City:	State:	ZIP Code:

Person Responsible for Account

Title:	First Name:	Middle Name:	Last Name:	Relationship to Patient:

Date of Birth (mm/dd/yyyy):	Social Security #:	Driver's Licence State & #:	Holder of Dental Insurance for Patient:
/ /	- -		

Home Phone:	Work Phone:	Cell Phone:	E-mail Address:
- -	- -	- -	

Billing Address:	City:	State:	ZIP Code:

Employment:	Employer's Name:	Employer's Phone:	Occupation:
		- -	

Employer's Address:	City:	State:	ZIP Code:

MARIO ROYBAL

Mario Roybal
1867 Popps Ferry Road
Biloxi, MS 39532
228-388-4519
dentistinbiloxims.com

Insurance Information

Primary Insurance

Insurance Holder's Name:	Date of Birth (mm/dd/yyyy): / /	Relationship to Patient:	Employer:

Member ID:	Group ID:	Insurance Company Name:	Insurance Company Phone: - -

Insured's SSN:	Insurance Company's Address:	City:	State:	ZIP Code:

Secondary Insurance

Insurance Holder's Name:	Date of Birth (mm/dd/yyyy): / /	Relationship to Patient:	Employer:

Member ID:	Group ID:	Insurance Company Name:	Insurance Company Phone: - -

Insured's SSN:	Insurance Company's Address:	City:	State:	ZIP Code:

Authorization

All of the above information is correct to the best of my knowledge. I authorize use of this form on all my insurance submissions and I authorize the release of information to all my insurance companies. I understand that I am responsible for my bill. I authorize Mario Roybal to act as my agent in helping me to obtain payment from my insurance companies. I authorize payment to Mario Roybal. I permit a copy of this authorization to be used in place of the original. I give Mario Roybal, its employees, and/or other agents express prior consent to contact me at any/all phone numbers, including cell numbers (by phone call or text message) and email addresses, for the purpose of treatment, insurance, or payment.

Signature (Type your name to sign electronically, or print and sign):	Date (mm/dd/yyyy): / /

Consent for Treatment

Patient Name:

I hereby authorize the doctor or designated staff to take X-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the dental needs of the above-named patient.

Upon such diagnosis, I authorize the doctor or designated staff to perform all recommended treatment mutually agreed upon by us and to employ such assistance as required to provide proper care.

I agree to the use of anesthetics, sedatives, and other medications as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

I have read, understood, and agree to the above treatment policy.

Signature (Type your name to sign electronically, or print and sign):	Date (mm/dd/yyyy): / /

MARIO ROYBAL

Mario Roybal
1867 Popps Ferry Road
Biloxi, MS 39532
228-388-4519
dentistinbiloxims.com

Payment

Does the person responsible for the account already have an account with this office? ❍Yes ❍No

Payment Method

Notice: Payment is due at the time of service unless alternative arrangements have been made in advance. Please choose a method of payment below.

Payment in Full

❍ Cash

❍ Check

❍ Credit Card

Type:	Credit Card Number:	Expiration: / 2015	Card Verification Code: VISA/MC/Discover: 3-digit code printed on back AmEx: 4-digit code printed on front

Your credit card information is kept on file for outstanding account balances.

Payment Plans

Start treatment immediately and pay over time with low monthly payments.

❍ CareCredit

No-Interest Payment Plans

- Pay for treatment over 6 or 12 months with NO interest.
- As long as you pay the low minimum monthly payment each month when due, and the balance in full by the end of the promotional 6- or 12-month term, no interest will be charged on your purchase.

Low-Interest Payment Plans

- Enjoy low monthly payments with the 24, 36, 48, or 60 month extended plans.
- The 14.9% APR is lower than average credit cards and makes convenient, fixed, and low minimum monthly payments possible. This option is available for treatment fees of $1000.00 or more. ($5000.00 or more for the 60 month plan.)

If you choose this option, you can fill out a CareCredit application at our office.

Would you like to discuss our office's financial policy? ❍Yes ❍No

Mario Roybal

Mario Roybal
1867 Popps Ferry Road
Biloxi, MS 39532
228-388-4519
dentistinbiloxims.com

Payment Policies

Thank you for taking the time to understand our payment policies. For any questions about fees, financial policies, or your responsibilities, please ask one of our office staff for clarification.

For Patients with Dental Insurance

We accept dental insurance assignments, with the understanding that any uninsured portion not covered by your insurance plan is to be paid by you at the time of service. As a courtesy, our office will file all applicable insurance forms. Please note that although we strive to provide accurate information, such information is not a guarantee of payment or eligibility with your insurance company and is only an estimate. Your dental insurance plan is a contract between you, your employer, and the insurance company. Depending on your specific insurance plan, your dental insurance may not fully cover our office dental fees for the services we render. The difference between our office dental fees and your insurance reimbursement is your responsibility.

Returned Checks

Personal checks that are returned due to "insufficient funds" are subject to a $25.00 service fee.

Service Charge

Payment is due at each appointment. I agree to pay any outstanding insurance balance within 60 days. If I do not pay the entire new balance within 60 days of the monthly billing date, a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate of 1.5% per month (or a minimum charge of $2.50 for a minimum balance of $25.00) which is an annual percentage rate of 18% applied to the last month's balance. In case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account balance or any future accounts. Please be advised that there is a $50.00 fee charged for missed or broken appointments without 24 hours notice. To avoid this charge, kindly give us a minimum of 24 hours notice for any appointment cancellation. Feel free to contact us at any time with questions you may have.

X-Ray/Records Release

There is a fee of $25.00 for any release of X-rays and/or records.

Minors

Adult patients are responsible for full payment at time of service. The adult accompanying a minor is responsible for payment. This office will not bill a non-custodial parent for services delivered to a minor. For unaccompanied minors, treatment may be denied unless charges have been pre-approved to a credit card or other payment arrangements have been made.

Authorization

Patient Name:

I hereby authorize payment directly to Mario Roybal of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of the above-named patient's dental treatment. The information on the page and the dental/medical histories are correct to the best of my knowledge. I grant the right to Mario Roybal to release the patient's dental and/or medical histories and other information about the patient's dental treatment to third-party payers and/or other health professionals.

Signature (Type your name to sign electronically, or print and sign):	Date (mm/dd/yyyy): / /