Patient Registration **PLEASE PRINT CLEARLY**

Have you been a previous patient LLU School of Dentistry? ___Yes ___No If yes, name if different___________________

How did you hear of LLU School of Dentistry? ___Relative/Friend ___Internet ___Billboard/Ads ___Health Fair ___Other___________

How do you prefer to be contacted? ___Home Phone ___Cell Phone ___Work Phone ___Text ___Email

- **Selecting text or email above will allow Loma Linda University School of Dentistry to send you convenient appointment reminders. You may opt out of this option at any time by notifying LLUSD Patient Business Office or your LLUSD Patient Care Coordinator.**

Patient's Name: ______________________________ **Date of Birth**: ___________
First Name MI Last Name

Gender: __Male __ Female __Other____________________ **SS#**: ________________

Marital Status: __Single __Married __Widowed __ Divorced __Separated

Ethnicity: __________ **Preferred Language**: __________ **Email Address**: ________________

Street Address: ______________________ **City/State/Zip Code:** ________________

Home Phone w/Area Code: ____________ **Cell Phone w/Area Code**: ________________

Patient's Employer: ______________________ **Work Phone w/Area Code:** ___________

Responsible Party if Patient is a Minor: ________________**Relationship:** __Parent __Other:________

I authorize LLUSD to discuss my treatment and finances with: ______________________

If you are receiving General Anesthesia today, please answer the following:

Name of person providing transportation for the patient: ______________________

Cell Phone Number w/Area Code: ____________ **Relationship to patient:** ___Parent/Guardian ___Caregiver ___Other

In case of emergency, contact: ______________________

Phone Number w/Area Code: ____________ **Relationship to Patient:** ________________

Reason for visit: ______________________

Referring Physician or Dentist Name & Phone number: ______________________

PLEASE PRESENT INSURANCE CARD(S) & PHOTO ID FOR COPYING AND COMPLETE THE FOLLOWING INFORMATION

Insurance Company Name 1: ______________________ **Ins Phone Number:** ___________

Employer: __________ **Primary Insured Name:** ________________ **Date of Birth:** ________

Group/Policy #: ________ **SS or ID #:** ____________ **Relationship to Patient:** _________

Insurance Company Name 2: ______________________ **Ins Phone Number:** ___________

Employer: __________ **Secondary Insured Name:** ________________ **Date of Birth:** ________

Group/Policy #: ________ **SS or ID #:** ____________ **Relationship to Patient:** _________

CONDUCT – Patient, Patient Legal Guardian, and/or Patient Representative:

- **Patient, patient's legal guardian, and/or the patient's representative shall be responsible for being respectful to LLUSD employees and dental staff and avoid the use of obscene language, threatening remarks, or other inappropriate or disruptive behavior.**

______________________________ ______________
Patient/Legal Guardian Signature Date

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Relationship to Patient

Loma Linda University School of Dentistry
Patient Business Office Billing Policy

Loma Linda University School of Dentistry (LLUSD) adopted the following billing policy. Please review this information and sign below.

- **I understand that it is my responsibility to provide the billing office or clinic department with current, accurate billing information at the time of check-in and to notify LLUSD of any changes in this information.**

- **I understand LLUSD Patient Business Office offers courtesy claims submission to selected carriers. I understand that my health care plan is a contractual agreement between me, my employer, and the insurance company. I understand that payment for all charges is ultimately my responsibility. I further understand that it is my responsibility to know my dental benefits and co-payments and to be prepared to pay prior to services being rendered.**

- **I understand that LLUSD Patient Business Office will verify my insurance eligibility, deductible amounts, and coinsurance amounts. I understand that the fee that I am quoted is an estimate based on 1) anticipated dental care needs and 2) current information provided to LLUSD Patient Business Office by my insurance carrier.**

- **I understand the LLUSD Patient Business Office will, upon my request, obtain insurance authorizations prior to rendering treatment. I further understand that prior authorization is not a guarantee of payment and that I am responsible for any bills not paid by my insurance carrier.**

- **I understand that I will be billed for any amounts due by me (co-payment amounts/deductibles and/or any balance unpaid by my insurance) and that I have a financial responsibility to pay these amounts.**

I hereby authorize LLU School of Dentistry to release my dental/medical information necessary to complete and process my insurance claims. I authorize LLU School of Dentistry to treat me and use my personal health information for healthcare operations.

I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to LLU School of Dentistry. I understand that I am financially responsible for any services not covered by my insurance carrier.

My signature below confirms that I have read these billing policies and my financial obligation as pertains to LLU School of Dentistry:

______________________________ ________________________

Patient/Legal Guardian Signature **Date**

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Relationship to Patient