Form Instructions

1. Use the tab key to move from form field to form field.

2. To enter text, tab to (or click) the area you would like to type in and begin typing.

3. Some form fields require a choice to be selected. Click in the boxed or underlined area and a check mark will appear.

4. To save the form and complete at a later time, click the disc button in the adobe reader tool bar at the top left of the page.

5. To print a copy of the form for your records, click the "Print Form" button at the bottom of the last page.

6. To send the completed form to our office, click the "Submit Form" button at the bottom of the last page.

If you experience difficulty submitting this form, please follow the instruction below:

1.Print the form

2. Complete the form with a pen and bring the form to the office at the time of your appointment.

3. If you do not have a printer, you may fill out the form at our office prior to your appointment. Please allow an extra fifteen minutes before your scheduled appointment. Please call our office if you have any questions.

For your protection:

This form is hosted on a secure server and may only be viewed by our office. You may feel confident in filling out this form, as all of your information will be kept safe and confidential during the process.

Insurance Waiver

Thank you for providing Gerald W. Bird, D.M.D., P.A. and Jay A. Johnson, D.M.D. with your complete and correct insurance information. This notice is to inform you of your obligation to our practice regarding the filing of your insurance claim. We will be happy to file an insurance claim to your *primary insurance carrier* as a courtesy to you. By filing your claim, we are in no way releasing you of your financial obligations and responsibilities.

For patients with insurance carriers that make payment to our office, our office may call for an *estimate* of insurance coverage for procedures in excess of $300. This is done when your surgery is scheduled on a different day from your consultation. In qualified cases, a down payment will be due. Down payments are unique for each surgical case and are not reflective of your co-payment or deductible only. In cases where your insurance carrier does not make payment to our office or benefits are limited, full payment will be due on the day of surgery. In all cases, the patient or their guardian are responsible for all fees charged by our office.

Once payment is received by your primary insurance carrier, we will determine the amount remaining. If there is a balance remaining, we will bill you with 30 day terms. If there is a credit balance, we will send a refund to the patient (usually within one week). Payment from your insurance carrier is expected within 45 days. If payment is not received within this reasonable time period, we will bill you for the balance remaining with 30 day terms. Please understand that no insurance carrier will guarantee payment of benefits; therefore, our office can offer no guarantee as to the amount you may owe.

I have read, understand and agree with all terms and conditions included within this insurance waiver.

Patient Name	Patient/Legal Guardian Signature *(18 years or older)*
Date	
Insured Member's Full Name	Insurance ID#
Insured's Date of Birth	Employer Name & Address
Primary Dental Carrier	Claims Address & Phone#
Primary Medical Carrier	Claims Address & Phone#