Oral Function SPECIALTIES

Connecting oral health and wellness through a lifetime

General Information

Name (First, M.I., Last) _____ Nick Name _____
Social Security Number _____ Date of Birth _____
Address _____ Home Phone _____ Cell _____
City, State, Zip _____ Email _____
Occupation _____ Work Phone _____
Check ____ Single ___Married ___Divorced ___Widowed ___Separated
If married, spouse's name _____
Person financially responsible for account _____
Relationship to patient _____ Social Security Number_____
Person to contact in an emergency _____ Phone _____
Dentist _____ Phone _____
Orthodontist _____ Phone _____
Physician _____ Phone _____
Speech Therapist _____ Phone_____
Whom may we thank for referring you to us? _____
Please describe why you are seeking an evaluation _____

Insurance

Do you have medical insurance? ___ Yes ___ No
Primary Medical Carrier
Insurance Holder's Name (First, M.I., Last)
_____
Patient's Relationship to Insured: Self Spouse Child Other
Insured Employer _____
Insurance Holder's SSN _____ DOB_____
Insurance Company _____ Policy Number _____
ID Number _____ Group Number _____

Your insurance is a contract between you and your insurance company. While we will help you collect the maximum benefits owed to you, our responsibility is to assess, examine, diagnose, evaluate and provide the highest quality treatment for your orofacial muscular needs. We request direct payment since insurance is considered a reimbursement to the patient. We will provide you with an itemized receipt so you may submit it to your insurance. While your initial referral may have come from your dentist, we have found that having a medical referral from your

physician is beneficial for reimbursement. We will provide you with an initial evaluation report and request for you to take it to your doctor and ask for this referral. If you have any questions concerning specific details of coverage for your plan, it is most effective if you contact your insurance company directly.

Signature:_____ Date:_____

Superbill Submission:

_____ I understand that I am responsible for submitting the superbill I receive from Oral Function Specialties to my insurance company.

_____ I understand that my insurance company may require preauthorization.

_____ I understand that my submission should include a letter of medical necessity AND a diagnosis from my doctor/dentist.

_____ I understand that my insurance company may or may not reimburse me for the treatment from Oral Function Specialties.

_____ I understand that it is my responsibility to communicate with my insurance company.

_____ I have read and understand the items stated above.

Patient/parent signature: _____ Date: _____