Doroschak DENTAL

Date _____

Thank you for selecting our dental health care team! We will strive to provide you with the best possible dental care. To help us meet your dental health care needs, please fill out this form completely in ink. If you have any questions or need assistance, we will be happy to help you.

Personal Patient Information (*Confidential*)

Full Name _____ Referred by: _____
Last First MI

Birth Date _____ Social Security # _____ ☐ Male ☐ Female

Address _____

City _____ State _____ Zip Code _____

Email Address _____

Employer & Occupation _____

Home Phone _____

Work Phone _____

Cell Phone _____

IMPORTANT!!!
I prefer to receive contact by:
☐ **PHONE CALL:**
Home / Work / Cell
Best Time of Day _____
☐ **TEXT**
☐ **EMAIL**

Will anyone other than you be calling to set up or confirm appointments? If yes, who:

_____

* In most instances, messages will be limited to appointment days/times and/or request to call our office for additional information.

Emergency Contact

Name _____ Relationship _____

Phone _____

Responsible Party *Who is responsible for the account (if different from above)?*

Name _____ Relationship _____

Birth Date _____ Social Security # _____

Address _____

City _____ State _____ Zip Code _____

Phone _____ Home / Work / Cell

Email Address _____

Employer _____ Occupation _____

Dental Insurance Information

Primary Insurance
Policy Holder Name _____
Relationship _____
Insured's birth date _____
ID/SSN # _____
Employer _____
Insurance Company _____
Group Number _____
Insurance Company Address _____
_____

Additional Insurance
Policy Holder Name _____
Relationship _____
Insured's birth date _____
ID/SSN # _____
Employer _____
Insurance Company _____
Group Number _____
Insurance Company Address _____
_____

Privacy Acknowledgement & Consent and Insurance Authorization

Check each item below with which you agree. Then please sign and date this form below. By signing this form, you agree to each statement you have checked.

☐ I have received a copy of this office's **Notice of Privacy Practices**.

☐ I have had the opportunity to read this office's **Notice of Privacy Practices** and now give my **consent*** for this office's use and disclosure of my protected health information (or the protected payment, and health care operations as defined in the **Notice of Privacy Practices**).

*You have the right to revoke this **consent** at any time by giving us written notice of our revocation. Please understand that any revocation will not affect any action we took in reliance on this **consent** before we received your revocation and that we may decline to treat you or continue treating you if you revoke this **consent**.

☐ I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me.

☐ I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for the payment of all services rendered on my behalf or my dependents.

Signature of patient (or parent/personal representative)

X _____ Date _____

Financial Arrangements

For your convenience, we offer the following methods of payment.
Please check the option which you prefer. Payment in full at each appointment.

☐ Cash (5% off if paid date of service with no account balance)

☐ Personal check (5% off if paid date of service with no account balance)

☐ Credit Card (circle one): Visa, Mastercard, Discover, or Care Credit

☐ I wish to discuss the dental office's policy.

THANK YOU for filling out this form completely. The information you have provided will help us serve you more effectively and efficiently. If you have any questions, please ask. You are entitled to a copy of this form if you wish.

Late Charges:
If I do not pay the entire new balance within 25 days of the monthly billing date, a late charge of 1.5% on the balance then unpaid and owed will be assessed each month (if allowed by law). I realize that failure to keep this account current may result in your inability to provide additional services, except for dental emergencies or where there is prepayment. In the case of default payment on this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this account or any future outstanding account balance.