

PATIENT INFORMATION

CONFIDENTIAL

PATIENT # _____
DATE _____

(PLEASE PRINT)

NAME _____ BIRTHDATE _____ HOME PHONE _____
FIRST MI LAST

ADDRESS _____ CITY _____ STATE _____ ZIP _____

CHECK APPROPRIATE BOX MINOR SINGLE MARRIED DIVORCED WIDOWED SEPARATED

PATIENT'S OR PARENT'S EMPLOYER _____ WORK PHONE _____

BUSINESS ADDRESS _____ CITY _____ STATE _____ ZIP _____

SPOUSE OR PARENT'S NAME _____ EMPLOYER _____ WORK PHONE _____

IF PATIENT IS A STUDENT, NAME OF SCHOOL/COLLEGE _____ CITY _____ STATE _____

WHO MAY WE THANK FOR REFERRING YOU? _____

PERSON TO CONTACT IN CASE OF AN EMERGENCY _____ PHONE _____

EMAIL ADDRESS _____

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT _____ RELATIONSHIP TO PATIENT _____
ADDRESS _____ HOME PHONE _____

DRIVER'S LICENSE # _____ BIRTHDATE _____ FINANCIAL INSTITUTION _____

EMPLOYER _____ WORK PHONE _____

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? YES NO

INSURANCE INFORMATION

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____
BIRTHDATE _____ SOCIAL SECURITY NUMBER _____ DATE EMPLOYED _____

NAME OF EMPLOYER _____ WORK PHONE _____

ADDRESS OF EMPLOYER _____ CITY _____ STATE _____ ZIP _____

INSURANCE COMPANY _____ GROUP # _____ UNION OR LOCAL # _____

INS. CO. ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOW MUCH IS YOUR DEDUCTIBLE? _____ HOW MUCH HAVE YOU USED? _____ MAX. ANNUAL BENEFIT? _____

* DO YOU HAVE ANY ADDITIONAL INSURANCE? YES NO IF YES, COMPLETE THE FOLLOWING:

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____
BIRTHDATE _____ SOCIAL SECURITY NUMBER _____ DATE EMPLOYED _____

NAME OF EMPLOYER _____ WORK PHONE _____

ADDRESS OF EMPLOYER _____ CITY _____ STATE _____ ZIP _____

INSURANCE COMPANY _____ GROUP # _____ UNION OR LOCAL # _____

INS. CO. ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOW MUCH IS YOUR DEDUCTIBLE? _____ HOW MUCH HAVE YOU USED? _____ MAX. ANNUAL BENEFIT? _____

X _____
SIGNATURE OF PATIENT OR PARENT IF MINOR

SIGNATURE

Dr. Pizzarello & Dr. Silvestro Family Dentistry

Financial Policy:

In order to help contain the rising cost of dental care we have developed a financial policy we feel is fair and reduces expense in the collection of fees. Fees for specific procedures are always available at the front desk. The doctors and staff will explain all treatment options available before treatment begins. Please feel free to ask all pertinent questions (i.e. time required, cost, expected outcomes) as many times as necessary **before** you agree to a treatment plan.

Payment is expected at the time services are rendered.

As a courtesy to our patients with insurance, we will bill the insurance carrier for covered treatment. However if insurance payment is denied for any reason and we are unable to obtain compensation for treatment, we expect full payment from patient. The patient is ultimately responsible to pay for services rendered.

For example: a \$1000 procedure will be completed in 3 appointments.

Case A Patient portion 1000	Amount due at each appointment (1000/3) = <u>\$333.33</u>
Case B Patient with insurance; 1000 - 50 = 950 Patient portion (950-450)= 500	50% coverage for treatment; 50 \$ deductible; Insurance estimate (950 x %50) = \$450 Amount due at each appointment (500/3) = <u>\$166.66</u>

In circumstances where a large treatment plan (over \$500) is undertaken and the patient would like to set up a payment plan, services will be provided and payment for services will be expected **before** the completion of treatment. If monthly payments are not made during the course of treatment, ongoing treatment will be temporized and treatment will be suspended.

Delinquent accounts (outstanding balance due over 90 days) will accrue a penalty of 10% APR., be referred for collection and the nation credit bureau. All reasonable collection and/or attorney fees are the responsibility of the patient.

If you request to have your dental records and radiographs (X-Rays) transferred to another office we can forward your radiographs and scanned treatment notes digitally.

We look forward to providing professional services for you and your family.

These policies are in effect as of 1 October 1995 and are subject to change.

Patient Signature _____ Date: _____