Dorothy Pasikowski D.D.S., P.C.

General & Cosmetic Dentistry

The Following Information Is Confidential And For Our Records Only.

Date ____/____/____

PATIENT INFORMATION

Name _____
First Middle Last

Age _____ Gender ☐ Male ☐ Female Date of Birth ____/____/____ Marital Status _____

Field Required

Email _____ Social Security # _____

Address _____
Street City ST Zip Code

Phone _____ Business Phone _____

Employer _____ Occupation _____

SPOUSE INFORMATION (Please fill out information below. If not applicable, skip).

Spouse's Name _____ Phone _____
First Last

Employer _____ Occupation _____

MINOR INFORMATION (Please fill out information below if patient is under 18. If not applicable, skip).

Parent's Name(s) _____ Phone _____
First Last

PREVIOUS DENTAL INFORMATION

Previous Dentist _____ Doctor's name_____

Have You Ever Had Orthodontic Treatment ( ) Yes ( ) No If Yes, What Office Did You Go To?_____

(On a Scale of 1 - 10. 10 Being The Most.)

When Was Your Last Dental Visit? ( )0-6mths ago ( )6-12mnths Ago ( )1-3 years ( )3+yrs

What Did You Have Done During Your Last Dental Visit? _____

PRIMARY INSURANCE

All Fields Are Required

Insurance Company_____

ID #_____

Name of Insured_____

Relationship to Patient _____
(If name on card is different)

SSN _____ DOB _____
(SSN is required for the Policy Holder)

Employer_____

SECONDARY INSURANCE

Insurance Company _____

ID # _____

Name of Insured _____

Relationship to Patient _____
(If name on card is different)

SSN _____ DOB _____
(SSN is required for the Policy Holder)

Employer _____

EMERGENCY CONTACT

Name_____ Relationship _____
First Last

Phone_____ Business Phone _____

How Will You Be Paying? ☐ Cash ☐ Check ☐ Card ☐ CareCredit

INSURANCE RELEASE

I hereby authorize Dorothy Pasikowski D.D.S., P.C. to furnish to the above named insurance company(s) all information which said insurance company may request. I hereby authorize payment to be made directly to Dorothy Pasikowski D.D.S., P.C., but not to exceed the charges incurred. I understand that I am responsible for payment not covered by my insurance.

Signature_____ Date_____

REFERRAL INFORMATION

Please check one:

__ Friend/ Family __ Insurance __Internet search __Location __Other

Please tell us who we can thank for referring you!

Name: _____

PRIMARY PHYSICIAN INFORMATION

Primary Physician _____ Phone _____

Have You Been Under The Care of a Physician in the Past 2 Years? ☐ Yes ☐ No If Yes, Explain: _____

_____

_____

Are You Taking Any Medication? ☐ Yes ☐ No If Yes, Please List: _____

_____

Have You Been Hospitalized or Had Any Surgeries in the Past 5 Years? ☐ Yes ☐ No If Yes, Explain: _____

_____

Please Circle All That Apply To You:

Heart Attack Heart Surgery Heart Disease Chest Pains Congenital Heart Disease Heart Murmur Asthma

High/Low Blood Pressure Artificial Pins/Joints Rheumatic Fever Stroke Ulcers/Stomach Trouble Diabetes

Kidney Disease Tuberculosis Hepatitis A/B/C HIV Positive A.I.D.S Radiation/Chemotherapy Liver Disease

Neurological Disorder(s) Epilepsy/Seizures Fainting/Dizzy Spells Shortness of Breath Blood Thinners Anemia

Arthritis Migraines Psychiatric/Psychological Care MVP

Please List Any Condition(s) or Symptoms Not Mentioned Above: _____

Are You (or is there a chance you could be) Pregnant? ☐ Yes ☐ No If Yes, Due Date: ___/___/___

Do You Smoke? ☐ Yes ☐ No If Yes, How Much? _____

Your Height _____ Your Weight _____ lbs

Are There Any Changes You Would Like to Make or Are You Experiencing Any Discomfort Regarding Your Smile/Mouth?

_____

_____

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Dorothy Pasikowski D.D.S., P.C. to use and disclose protected health information about me to carry out treatment, payment and/or healthcare operations. I understand that I have the right to review the Notice of Privacy Practices prior to signing this consent.

With this consent, Dorothy Pasikowski D.D.S., P.C. may call my home or an alternative phone number and leave a message on voicemail or in person in reference to any items that assist the office in carrying out healthcare operations, such as: confirming appointments, insurance clarification or calls pertaining to my clinical care. They may also mail to my home any items regarding the prior information, such as patient statements and appointment reminders.

I understand that I can revoke my consent in writing except to the extent that the office has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Dorothy Pasikowski D.D.S., P.C. may decline any treatment to me thereafter.

Signature of Patient or Parent/Legal Guardian _____

Date ___/___/___

Dorothy Pasikowski D.D.S., P.C.
General & Cosmetic Dentistry

INSURANCE

Due to the number of insurance carriers and their changing policies, we are unable to determine your exact insurance coverage. We can only provide you with general plan information at the time of your visit. For your protection, please don't assume that you have coverage without checking with your insurance carrier prior to treatment.

We require your co-payment and deductible (if applicable) on the day of your treatment prior to treatment. Your copayments are only an estimate. If there is a balance after insurance pays, a statement will be sent to you. Please allow 2-6 weeks for insurance payment on your claims. You are ultimately responsible for your bill regardless of insurance.

Please do not be hesitant to ask us any questions about our office policies. We want you to be comfortable in dealing with these matters and we urge you to consult us if you have any questions regarding our services and/or fees. As a service for our patients, we will submit insurance claims at no charge. We will do all we can to assist you in maximizing your allowable benefits.

If we take assignment on your insurance, we feel that 45 days is a reasonable length of time for us to wait for payment from your insurance company. Should payment not be received within that time, payment of services rendered will be the responsibility of the patient.

NO INSURANCE

Patients without insurance will be required to pay in full on the day of treatment. We accept all major credit cards (MasterCard, Visa, Discover, Amex) and we also accept Care Credit. We do provide a discount for those who do not have dental insurance coverage. We also provide a discount to those without dental insurance.

OVERDUE ACCOUNTS

Accounts that are over 60 days past due could be placed with an outside collection agency for recovery. In the event that your account is turned over to an outside collection agency, a 30% collection fee will be added to your balance. Should it become necessary to collect an overdue account, the patient, or the patients' responsible party understands that Dorothy Pasikowski D.D.S., P.C. has the right to disclose all relevant account information necessary to collect payment(s) for services Rendered

There is a returned check fee of $35 for any returned checks.

NO-SHOW/CANCELLATION POLICY

We value your time with us, and expect the same in return. If you cannot keep your appointment, please give us a 24 Hour notice so that we can give this time to someone else. We charge a $50.00 fee for no show or cancellation of an appointment if we don't receive a 24 hour notice.

I have read and understand the above and agree to the terms and conditions.

Signature of Patient or Parent/Legal Guardian _____

Date ____/____/____