ZIELINSKI DENTAL

PATIENT REGISTRATION Male ___ Female___

Last Name: _____First Name: _____ Date: _____

Preferred Name: _____ Driver's License Number: _____

Birth Date: _____ **Social Security #**:_____ Marital Status: _____

Address: _____City,State,Zip:_____

Cell Phone: _____ Would you like to receive **Text correspondence? Y__ N__**

Home Phone: _____ Work Phone: _____ Ext:_____

Email: _____ Would you like to receive **Email correspondence? Y__ N__**

Whom may we ***THANK*** for referring you? _____

Responsible Party (**IF** someone other than the patient)

Name: _____Relation: _____**Social Security #**:_____

Employer:_____ Home Phone: _____

Address:_____City,State,Zip:_____

Primary Insurance

Name of Insurance:_____ Relationship to Insured: Self__Spouse__Child__Other__

Plan/Group #:_____Insured SSN: _____Insured Birth Date: _____

Employer: _____ Ins Company Phone #:_____

Employer Phone #:_____

Amount of Deductible: _____ Max Annual Benefits: _____ Amount Used: _____

Secondary Insurance

Name of Insurance:_____ Relationship to Insured: Self__Spouse__Child__Other__

Plan/Group #:_____Insured SSN: _____Insured Birth Date: _____

Employer: _____ Ins Company Phone #: _____

Employer Phone #:_____

Amount of Deductible: _____Max Annual Benefit: _____ Amount Used: _____

Emergency Contact Name: _____ Phone Number: _____ **OVER ->**

IMPORTANT INFORMATION REGARDING YOUR DENTAL CARE

SCHEDULING

When an appointment is made for you, the time of the doctor, staff and the room is reserved for you alone. Missed appointments are costly to everyone. They delay your treatment and prevent us from seeing other patients in need. It is important for everyone that you keep the appointments that you make.

Appointments cancelled with less than 24 hour notice are subject to a $25 rescheduling charge. Anyone arriving late to an appointment may need to reschedule and a $25 charge may apply.

Patients who miss or cancel three appointments without 24 hour notice will be dismissed from the practice.

INSURANCE

Dental insurance is intended to cover some, but not all of your dental care. Most plans include deductibles, co-pays and maximums. There also may be recommended services that while can be performed may not be a covered benefit. Reimbursement amounts are not, and have never been, a guideline for quality of care. However, we do try to make the most of your benefit that is available to you.

It is important that you understand when you receive a treatment plan from our office it is an estimate only. There are many insurance companies and they routinely change their reimbursement amounts. Your dental benefit depends on the contract your employer has established with the insurance company.

PAYMENT

Payment is expected at the time of service. If you have insurance you will be expected to make an estimated payment for that portion not covered by your insurance plan. We offer several payment options:

Cash or Personal Check

Credit Card: MasterCard, Visa, Discover, and American Express

Care Credit: Including 3, 6, and 12 month payment plans. You can apply online if necessary

I have read and understand the above information.

Signature of Patient, Parent, or Guardian Date