

PATIENT INFORMATION

PATIENT _____ HOME PHONE _____
Last First Middle
EMAIL(OPTIONAL) _____ CELL PHONE _____
ADDRESS _____ BUS. PHONE _____
CITY _____ STATE _____ ZIP CODE _____
EMPLOYER _____ SOCIAL SECURITY # _____
DATE OF BIRTH ____/____/____ SEX M ____ F ____ SINGLE ____ MARRIED ____ WIDOWED ____ DIVORCED ____

INSURANCE POLICY HOLDER _____ DATE OF BIRTH ____/____/____
SEX M ____ F ____ SINGLE ____ MARRIED ____ WIDOWED ____ DIVORCED ____
POLICY HOLDER ADDRESS (if different from patient) _____
RELATION TO PATIENT: SELF ____ SPOUSE ____ PARENT ____ OTHER ____
EMPLOYER _____
PRIMARY DENTAL PLAN _____ COMPANY PHONE _____
PLAN ADDRESS _____
GROUP # _____ MEMBER ID # _____

NAME OF PREFERRED PHARMACY _____ PHONE _____
NAME OF EMERGENCY CONTACT _____ PHONE _____
IS ANY MEMBER OF YOUR IMMEDIATE FAMILY A PATIENT HERE? _____
WHO REFERRED YOU TO OUR OFFICE? _____
GENERAL DENTIST NAME _____

CANCELLATION POLICY

We understand that on occasion cancellations are necessary. Please remember that each appointment time is reserved exclusively for that individual patient. Therefore, we require 48 hours notice to reschedule or cancel an appointment. This enables us to offer that appointment to someone else who needs it. Thank you for making every effort to keep your appointments.

PERMISSION FOR TREATMENT

This is to certify that I, the undersigned, consent to the performance of any and all procedures and the use of any and all drugs that are agreed to be necessary or advisable.

PROMISE OF PAYMENT

I hereby authorize Matthew D. Ficca, DMD, MSD, PA to furnish information to insurance carriers concerning services rendered. I understand that I am financially responsible for all charges, whether or not they are covered by my insurance. We ask that payment is rendered at the time of service. As part of our service to you, we file your insurance claim, in an attempt to speed up and maximize the benefit you are entitled, for re-imbursement directly to you.

SIGNATURE OF PATIENT

DATE