WELCOME!

We appreciate you choosing our office for your dental needs. The following information will be held in strict confidence and will never be released without your written consent.

PATIENT INFORMATION

Name ☐ (M ☐ F) ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. Nickname

Home Address City State Zip

Home phone Work E-mail

Birth Date Social Security # Employer

Name of Spouse Spouse's Employer

Would you like us to give you a reminder call before your appointments?

Whom may we thank for referring you to our office?

Closest relative not living with you: Phone:

Address City State Zip

ACCOUNTS FOR CHILDREN

If patient is under 18 years old, please complete the following. Please be aware that the adult who brings the child to the appointment is responsible for the account. We are unable to bill a parent who is not present at the appointment.

Parent bringing child: Date of birth

Home phone Work phone Social Security #

Address: City State Zip

I authorize the dental staff to perform the necessary dental services my child may need:

SIGNATURE OF PARENT OR GUARDIAN DATE

DENTAL INSURANCE INFORMATION

Insured Employee Employer

Social Security # Date of birth Group #

Insurance Company Insurance company phone number

Claims address City Zip

Are you covered by a second carrier /dental insurance plan?

FINANCIAL INFORMATION

Thank you for choosing our office for your dental needs. We will be happy to work with you in planning your treatment to fit your budget. We do ask that you pay in full for treatment on the day that it is performed, and our Financial Coordinator will be happy to give you an estimate of your patient portion before your treatment. If you should need extensive dental treatment, we gladly offer extended payment plans but arrangements must be made with our Financial Coordinator in advance of treatment. For your convenience, we accept cash, checks ($30.00 fee for returned checks), and Visa/MasterCard/AMEX/Discover as payment. We will consider all accounts that are over 30 days subject to a $5.00 billing fee or 1.5% of the balance service charge (whichever is greater).

For our patients who have dental insurance, we are happy to accept the assignment of your insurance benefits directly to our office. Please be aware that your estimated portion will be due on the day of treatment, and we can **never guarantee** an exact amount that your carrier will pay. You will be financially responsible for any remaining amount not paid by your insurance carrier including: deductibles, co-payments, service or charges denied by the carrier, or amounts over your carrier's allowances. We will also ask that you pay any claim not processed by your insurance company within 60 days (you will be notified after it is outstanding for over 45 days).

Should you be unable to keep a scheduled appointment, please inform our office at least two business days in advance. Without proper notice, a charge will be made for the scheduled time.

Please sign below so that we know that you have read and understand the above financial procedures and agree to all terms. If you have any questions please speak to our Financial Coordinator when you arrive for your appointment.

PATIENT/ GUARDIAN SIGNATURE: _____ DATE _____

ASSIGNMENT OF BENEFITS

As a service to our patients, we accept the assignment of your insurance benefits directly to our office upon verification of coverage. We try our best to estimate your patient portion based on the information given to us by your insurance carrier but **we can never give you a guarantee of coverage**. Our Financial Coordinator will be happy to go over these in detail before your initial appointment. Your insurance carrier states they cover the following amounts:

Preventive services _____ Restorative services _____ Major services _____

Deductible _____ **(annually/lifetime not applied to preventative**) Maximum: _____ (annual /lifetime)

I, the undersigned, understand the above financial policy, and assign directly to Mark G. Sayeg, D.D.S. all benefits that would be payable to me for dental services rendered. I hereby authorize this office to use this signature on all of my insurance submissions and allow the release of any information necessary to secure the payment of benefits. I understand that I am responsible for any amounts not paid by my insurance company within sixty days.

PATIENT/ GUARDIAN SIGNATURE: _____ DATE: _____

YOUR PRIVACY

Your privacy is assured here in our office, and your health records will never be released without your consent. Along with your forms you have been provided a copy of our Privacy Policies as required by the HIPAA Privacy Act (proposed by the US Department of Health and Human Services – effective April 1, 2003). Please sign this so we know you have received a copy of our privacy practices.

PATIENT / GUARDIAN SIGNATURE: _____ DATE: _____

PHOTOGRAPHY RELEASE

I authorize the office of Mark G. Sayeg, DDS to take photographs slides and/or videos of my face, jaws, and teeth. I understand that any of these are used in any educational purposes or as a part of a demonstration; my name or any other identifying information will be kept confidential. I do not expect compensation, financial or otherwise for the use of these photographs.