PATIENT INFORMATION & FINANCIAL AGREEMENT

Date: ________________

Pamela Z. Baldassarre, D.M.D. Practice Limited to Periodontology

Patient Name: Dr/Mr/Mrs/Ms/Miss

Address:

City State: ZipCode:

Home Phone: ( ) Work Phone: ( ) ext:______

Cell Phone ( ) Email Address:

APPOINTMENTS ARE CONFIRMED ELECTRONICALLY. PLEASE PROVIDE THE ABOVE INFORMATION – THIS INFORMATION WILL NOT BE USED BY OUTSIDE SOURCES.

Birthdate: SSN: Nickname:

Referring Dentist Physician:

Person to contact in emergency: Phone

Guarantor of Account:

AUTHORIZATION & RELEASE

_____ I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me, or my child, during the period of such dental care to third party payers and/or other health practitioners.

FINANCIAL AGREEMENT

*Your dental plan may cover only part of your dental treatment, if any. It is understood that you are responsible for the entire balance on your account. As a courtesy, there is no charge for submitting your dental claim; however, any dispute on fees is between you and your insurance carrier.

_____ I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me

_____ I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependent's.

_____ I understand that verbal and written predetermination of benefits are not a guarantee of payment.

_____ I understand that a $75 cancellation fee MAY be applied for cancellations without 48 hours' notice.

Signature: ____ Date: _____________

Print Name: ____

Primary DENTAL INSURANCE INFORMATION

Plan Description:

(Ins. Co.) Address:

Insured Party: DOB:

Insured Party ID: Insured Party SSN:

Employer Name:

Group No: Group Name:

Policy Start Date: Policy End Date

Deductible Met: Annual Maximum:

Secondary DENTAL INSURANCE INFORMATION

Plan Description:

(Ins. Co.)Address:

Insured Party: DOB:

Insured Party ID: Insured Party SSN

Employer Name:

Group No: Group Name:

Policy Start Date Policy End Date:

Deductible Met: Annual Maximum:

PLEASE PROVIDE US WITH CURRENT COPIES OF YOUR MEDICAL AND DENTAL INSURANCE CARDS