Welcome

Wanezek Family Dentistry

Date_______________

Patients Name____Date of Birth____________ ☐Male ☐Female
Last First Initial

Preferred Name______________________________________
Single☐ Married☐ Separated☐ Divorced☐ Widowed☐ Minor☐

Residence-Street___________________________________

City____

Business Address__________________________________

Telephone: (Home)_____________(Work)_____________

Cell #_______________

Social Security #______________________________________

Email____

Patient/Parent Employed by_________________________

Present position___________________________________

How long held_____________________________________

Spouse Name______________________________________

Spouse Employed by_________________________________

Present position___________________________________

Who is responsible for this account___________________

Method of payment: Insurance☐ Cash☐ Credit Card☐

Other Family Members in this Practice________________

____

Whom may we thank for this referral?_________________

Emergency contact not living with you_________________

____

Primary Insurance

Employee Name:___________________________________

Date of Birth:_____________________________________

Employer Name:___________________________________

Name of Insurance Co.______________________________

Address____

____

Telephone____

Program or Policy#_________________________________

Social Security #__________________________________

Union, Local or Group #_____________________________

Secondary Insurance

Employee Name___________________________________

Date of Birth: ____________________________________

Employer Name___________________________________

Name of Insurance Co. ____________________________

Address:____

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Telephone____

Program or Policy #________________________________

Social Security #__________________________________

Union, Local or Group #_____________________________

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient's account and that he or she is personally responsible for payment of all dental services not covered by the insurance company. This office will help prepare the patients insurance form or assist in making collections from insurance companies and will credit any such collections to the patients account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. Patients are required to pay their estimated portion of the services rendered at the time of service. I understand that the fee estimate listed for this dental care can only be extended for a period of three months from the date of the patient examination and is subject to insurance benefits. In consideration for the professional services rendered to me, or at my request, by the doctor, I agree to pay therefore the reasonable value of said doctor, or his assignee, at the time said services are rendered. I grant my permission to you or your assignee, to telephone me at home or at work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their consent.

____ **Date:**__________________ **Relationship to Patient**____________________
Signature of patient, parent or guardian