

Welcome!

1 Patient Information

Name _____ Date _____
Social Security # _____ Birthdate _____
Wishes to be called: _____

2 Responsible Party

Who is responsible for the account?

Name _____ Relationship to patient _____
Birthdate _____ Driver's License # _____
Social Security # _____
Address _____
City, State, Zip _____
Employer _____
Occupation _____
Work Phone _____ Ext. # _____
Home Phone _____
Where do you prefer to receive calls? Home Work Car
When is the best time to reach you? Time _____ Days _____
In the event of an emergency, who should we contact? Name _____
Relationship _____ Work # _____ Home # _____

3 Dental Insurance Information

Primary Insurance

Name of Insured _____
Relationship to Patient _____
Insured's Birthdate _____
Soc. Sec. # _____
Employer _____
Date Employed _____
Occupation _____
Insurance Company _____
Group # _____
Employee / Cert. # _____
Ins. Co. Address _____

Additional Insurance

Name of Insured _____
Relationship to Patient _____
Insured's Birthdate _____
Soc. Sec. # _____
Employer _____
Date Employed _____
Occupation _____
Insurance Company _____
Group # _____
Employee / Cert. # _____
Ins. Co. Address _____

4

Authorization and 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 payors and/or other health practitioners.

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 dependents.

X _____
Signature of patient or parent if minor Date

5

Financial Arrangements

For your convenience, we offer the following methods of payment. Please check the option which you prefer. Payment in full is expected at each appointment.

- _____ Cash
- _____ Personal Check
- _____ Credit Card: Visa MC Discover
- _____ I wish to apply for Care Credit
(Low monthly payment plan with interest free financing programs available)
- _____ I wish to discuss the dental office's policy

6

Late Charges

If I do not pay the entire new balance within 25 days of the monthly billing date, a late charge of 1.5% on the balance then unpaid and owed will be assessed each month (if allowed by law). I realize that failure to keep this account current may result in you being unable to provide additional dental services except for dental emergencies or where there is prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.

X _____
Signature of Patient or Parent of Minor

HAMPTON BAYS DENTAL ASSOCIATES, PC
Kevin Sheren, DDS • Madeline Shakin, DDS
 Hampton Medical Atrium
 182 West Montauk Highway, Building B, Suite E
 Hampton Bays, NY 11946
 Phone: (631) 728-8400 • Fax: (631) 728-8482