

PATIENT INFORMATION FORM

NAME _____

HOME ADDRESS _____

DATE OF BIRTH _____ SOCIAL SECURITY NUMBER _____

HOME PHONE: _____ MARITAL: S/M/D/W _____ REF. DOCTOR _____

WORK PHONE: _____ GENDER: M / F _____ REF. PATIENT _____

PRIMARY DENTAL INSURANCE COVERAGE

SUBSCRIBER NAME: _____ RELATION TO PATIENT: _____

ADDRESS: _____

SSN: _____ EMPLOYER: _____

DOB: _____ ADDRESS: _____

PLAN NAME: _____ GROUP NO. _____

INSURANCE CO: _____ IND. YRLY DEDUCT: _____

ADDRESS: _____ FAM YRLY DEDUCT: _____

SECONDARY DENTAL INSURANCE COVERAGE

SUBSCRIBER NAME: _____ RELATION TO PATIENT _____

ADDRESS: _____

SSN: _____ EMPLOYER: _____

DOB: _____ ADDRESS: _____

PLAN NAME: _____ GROUP NO. _____

INSURANCE CO: _____ IND. YRLY DEDUCT: _____

ADDRESS: _____ FAM YRLY DEDUCT: _____

FINANCIALLY RESPONSIBLE PARTY

Name and Relationship _____ DOB _____

Address _____ SSN: _____

PHONE () _____ Bus. PHONE () _____

FINANCIAL RESPONSIBILITY: This information is accurate and to the best of my knowledge. I understand that payment is due at the time of service. I further understand that if payment becomes 60 days past due, I will be charged interest of 1.5% per month and reasonable attorney's fees and costs of collection in the event of default.

Signature

Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

{Please print name} _____, have received a copy of this office's Notice of Privacy Practices

Signed: _____ Date: _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- D Individual refused to sign
- D Communications barriers prohibited obtaining the acknowledgement
- D An emergency situation prevented us from obtaining acknowledgement
- D Other (Please Specify)

Carl A. Murano D.D.S.
14 South Church Street
Honeoye Falls, New York 14472
585-624-1917

OFFICE PHILOSOPHY AND POLICIES

Our office is here to serve you. We believe that the soundest approach to oral health is one of prevention. With routine care and maintenance, we hope to help you maintain your oral health. If we find and take care of small problems early on, hopefully we can maintain health and prevent more extensive and costly treatment in the future. We comply with all current infection control recommendations in an effort to safeguard our patients.

Please notify us if there is any change in your medical history. This is very important. This allows us to take into account any medical condition, which may bear directly upon your dental care.

If you would like, we will set up your periodic maintenance appointments (cleaning and examination) for you. This is an attempt to insure that you receive care in a timely fashion.

(CHECK ONE)

please set up my maintenance visits (exam and cleaning) and send me a post card with the date and time

I will call to make my own maintenance appointments.

As a general rule, we do not double book for routine and elective care. Since we reserve time exclusively for you, we require at least 24 hours notice to change an appointment. Broken appointments or late cancellations will be billed a \$25 broken appointment fee per 30- 45 minute time block.

We will submit insurance claims for you. This is done as a courtesy, as we do not belong to any "insurance" plan. We work for you -not the insurance company!!

Payment is due at the time of service. Any balance over 60 days will be assessed a 1.5% per mo. (18% annual) fee to cover billing and administrative costs. This is regardless of whether, if, or when your insurance company pays.

If you have any concerns regarding your care or our office policies, please feel free to discuss them with us and please do so promptly so that we can avoid any misunderstanding.

I have read and understand the office policy and philosophy statement

Signed

Date