Koza Family Dental Care, P.C.

Our mission and purpose is to provide excellent dental care to our patients, to treat them with honesty and compassion, and to serve the community in which we live and work.

Name: _____

I prefer to be called: _____

Birthdate: ___/___/___ Age: ___ □ Male □ Female

Home Address: _____

_____

Hm#: _____ Cell# _____

Wk# _____ Ext: _____

When and where are the best times to reach you? _____

_____

Employer: _____

Employer Address: _____

_____

Other family members seen by us: _____

Person responsible for account

Name:_____

Address: _____

Hm#:_____ Wk: _____

Birthdate: _____ Relation: _____

For Emergency Purposes

Relative or Friend not living with you

Name: _____ Relation: _____

Hm#: _____ Wk#: _____

Insurance: _____

Group#: _____

Insured's Name: _____

Insured's Birthdate: _____ Relation: _____

Insured's ID#: _____

Insured's Employer: _____

Yearly Maximum _____ Benefits used: _____

Secondary Insurance: _____

Group#: _____

Insured's Name: _____

Insured's Birthdate: _____ Relation: _____

Insured's ID# _____

Insured's Employer: _____

Yearly Maximum: _____ Benefits used: _____

Payment Method:

□ Cash □ Check □ Debit □ Credit Card □ Other

Where did you hear about our office?
(Please circle or specify other)

Newspaper Friend Internet Other _____

(Please fill out both sides)

Payment is due in full at the time of treatment

(Please Read Before You Sign)

I understand that I am responsible for payment at the time of treatment and also responsible for paying any co-payment and deductibles that my insurance does not cover. I authorize payment directly to Koza Family Dental Care, P.C. of the group insurance otherwise payable to me. I authorize release of information, including the diagnosis and treatment rendered to my insurance company. I understand that I am responsible for all costs of dental treatment. I also understand that if a statement is required for any unforeseen remaining balance, the first statement will be issued with no extra charges. A cumulative $5.00 rebill fee will be charged and added to each subsequent statement.

Consent for treatment

I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in strictest confidence and that it is my responsibility to inform this office of any changes in my medical status. I authorize Koza Family Dental Care, P.C. to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

Records release

I authorize Koza Family Dental Care to release my dental records at my request to another dental provider if necessary.

Signature of patient or parent if child Date