THADDEUS S. MICHALSKI D.M.D.

GENERAL, COSMETIC AND IMPLANT DENTISTRY

Blending the Art & Science of Dentistry

So that we may provide the best of care, please fill out both sides of these forms completely

Patient Information

Last Name: _____ First Name: _____ MI: ____ Date: _____

Nickname/Preferred Name: _____ Birth Date: ____ /____ /____ ☐ Male ☐ Female

☐ Married ☐ Single ☐ Child ☐ Other _____ If married, name of spouse: _____

SS # _____ Driver's License # _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: Home: _____ Work: _____ Ext: _____ Best time to call: _____

Cell: _____ Email: _____

How do you prefer for us to confirm your visits: ☐ Email ☐ Cell/Text ☐ Home ☐ Work ☐ Other: _____

Occupation: _____ Employer: _____

Responsible Party Information (If different from above)

Last Name: _____ First Name: _____ MI: ____ Date: _____

Relationship to patient: _____ Birth Date: ____ /____ /____ ☐ Male ☐ Female

☐ Married ☐ Single ☐ Child ☐ Other _____ If married, name of spouse: _____

SS # _____ Driver's License # _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: Home: _____ Work: _____ Ext: _____ Best time to call: _____

Mobile/Cell: _____ Email: _____

Occupation: _____ Employer: _____

Referral Information

Please tell us how you heard about our practice? ☐ Patient ☐ Dental Office ☐ Yellow Pages ☐ Internet

☐ Newspaper ☐ Television ☐ Mailer ☐ Work ☐ Other: _____

Whom may we thank for referring you to our practice? _____

Primary Dental Insurance Information

Name of Insured: _____ Birth Date: ____ / ____ / ____
Last First MI

Relationship to patient: _____ ID # _____ Group # _____

Insurance Plan Name: _____ Phone: _____

Insurance Plan Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Please complete *BOTH* sides➔

Secondary Dental Insurance Information

Name of Insured: _____ Birth Date: ____ / ____ / ____
Last First MI

Relationship to patient: _____ ID # _____ Group # _____

Insurance Plan Name: _____ Phone: _____

Insurance Plan Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Consent for Services

I acknowledge that this office, as a courtesy, will file with my insurance company for its portion of the fees incurred on the date of my visit and will credit any such collections to my account. I understand that all dental services furnished are charged directly to the patient and that I am personally responsible for payment of all dental services, including any balances not paid by my insurance carrier regardless of the basis for their nonpayment. Notifying this office of any change in my insurance coverage is my responsibility.

My portion of fees for procedures performed is due upon completion (regardless of insurance coverage) unless prior financial arrangements have been made. Such arrangements must be in writing. I understand that the fee estimate listed for any dental treatment can only be extended for a period of 90 days from the date of the patient examination.

I agree that I am responsible for any unpaid balance on my account and that a service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied. This includes any dependents for whom I am also responsible. The office has also informed me that there will be a $25.00 service charge on any returned check.

I authorize this office to provide any insurance company, health care service plan, self-insurers, or their representatives, any and all information and records about my medical history, or about services rendered or treatment given to me that is needed to review, investigate or evaluate any claims for benefits.

I understand and acknowledge that photographs and images of me may be shown to our laboratory, doctors and other patients for the purpose of communicating, recordkeeping, and for use in educational presentations or publications. Pictures shown are only of the teeth and oral cavity, and do not reveal the identity of the subject.

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

_____ Date: _____ Relationship to Patient: _____
Initials of patient, parent or guardian

Unfortunately, it has become necessary to institute a policy for last minute cancellations and no shows. The first time that you do not show up for a scheduled appointment or call 24 hours in advance to cancel, we will call to reschedule your appointment and gently remind you of this policy. The second occurrence will be a $35.00 charge. The third occurrence within a 1 year period may lead to discharging you from the practice.

I have received and understand this policy.

_____ Date: _____ Relationship to Patient: _____
Initials of patient, parent or guardian

Thank you for understanding and your anticipated cooperation.