Patient Information Form

PATIENT NAME:_____ PATIENT PREFERRED NAME:_____

PATIENT DOB:_____ PATIENT SSN:_____

STREET ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

HOME PHONE:_____ MOBILE:_____ OTHER:_____

EMAIL:_____

What is the best way to reach you?_____

Whom may we thank for referring you?_____

RESPONSIBLE PARTY NAME:_____

RESPONSIBLE PARTY DOB:_____ RESPONSIBLE PARTY SSN:_____

STREET ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

HOME PHONE:_____ MOBILE:_____ OTHER:_____

RELATIONSHIP TO PATIENT:_____

PRIMARY DENTAL INSURANCE

SUBSCRIBER:_____ DOB:_____

SUBSCRIBER SSN:_____ MEMBER ID#:_____

SUBSCRIBER RELATIONSHIP TO PATIENT:_____

EMPLOYER/PLAN NAME:_____GROUP #:_____

DENTAL INSURANCE PROVIDER:_____ PHONE:_____

DENTAL INSURANCE ADDRESS:_____

SECONDARY DENTAL INSURANCE

SUBSCRIBER:_____ DOB:_____

SUBSCRIBER SSN:_____ MEMBER ID#:_____

SUBSCRIBER RELATIONSHIP TO PATIENT:_____

EMPLOYER/PLAN NAME:_____GROUP #:_____

DENTAL INSURANCE PROVIDER:_____ PHONE:_____

DENTAL INSURANCE ADDRESS:_____

drgavros@doragavros.com Dora Koros Gavros, DDS 415.435.3111

Financial Agreement

PLEASE INITIAL WHERE INDICATED, SIGN AND DATE BELOW

PATIENTS NAME (PLEASE PRINT) :_____

INITIAL _____ I agree to be responsible for keeping all scheduled appointments. If I am unable to keep my appointment, I agree to call the office to change my appointment at least 48 business hours in advance so that someone else may have that time.

INITIAL _____I agree that if I fail my scheduled appointment or cancel within 48 business hours of my appointment, I will be given a onetime courtesy credit for that missed appointment. After that, I will be charged $150.00. I agree to pay this amount. I understand that insurance cannot be billed for this charge that I am responsible for.

INITIAL _____ I understand that payment is due in full at the time services are rendered unless other financial arrangements have been made in advance of my appointment. I understand that some services do require multiple appointments. I understand that I am required to make a downpayment of half of the total charges due at the initial visit and I must pay off the total balance by the time treatment is completed. I also understand that should my account balance become delinquent and interest accrues, I am responsible for these charges and agree to pay them along with the overdue balance. Should the account be turned over to a collection agency, I agree to pay for any additional fees that are incurred.

INITIAL_____ I understand that your office submits claims to my dental insurance as a courtesy to me. I agree that if my insurance is canceled or if they do not cover a particular service. I am financially responsible. I understand that your office will do your best to get the maximum possible coverage on my behalf but, any amount not covered by my insurance plan policy will ultimately be my responsibility.

By signing below you acknowledge that you understand our Office's Financial Policies.

Patient Signature:_____**Date**: _____

Parent/Guardian Signature:_____**Date**:_____

(If patient is a minor)

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Credit Card Authorization Form

REQUIRED FOR ALL PATIENTS

The office of **Dora Koros Gavros, DDS**, requires that every new patient maintain a credit card on file for any outstanding payments due, including missed appointment fees. Our postcards, emails, appointment cards, and phone messages all ask for 48 business hours notice if you need to change an appointment. When we know ahead of time that a patient is unable to make their scheduled appointment, we can offer that time to someone else who is waiting to be seen. Without this notice, the time is lost. The first time this happens, we allow a onetime courtesy credit for the missed appointment charge. After that, there will be a $150.00 fee charged to the credit card on file for every missed appointment. This form must be submitted at the time of your appointment and kept current.

PATIENT: _____ **DOB:**_____

BILLING INFORMATION:

CARD HOLDER NAME:_____

CARD NUMBER:_____

EXP DATE:_____ SECURITY CODE*:_____ BILLING ZIP:_____

(*AMEX 4 DIGIT ON FRONT OF CARD, ALL OTHER CARDS 3 DIGITS ON BACK)

_____EMAIL RECEIPT TO:_____

_____ MAIL RECEIPT TO:_____

I will pay for all services at the time they are rendered. I authorize the Office of Dora Koros Gavros, DDS to charge the above credit card for any outstanding balance for dental services provided or any missed appointment fees.

CARDHOLDER SIGNATURE:_____ DATE:_____

Dora Koros Gavros DDS

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, acknowledge that I have received a copy of this office's **Notice of Privacy Practices** and a copy of the **Dental Materials Fact Sheet** dated 5/02*.

Patient Signature:_____ **Date**:_____

_____

(If patient is a minor, Parent or Guardian Signature)

*You may refuse to sign this acknowledgment.

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:

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

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