



Welcome to our Practice!

Date _____

Patient: (Mr., Mrs., Ms., Dr.) First Name _____ M.I. _____ Last Name _____

Nickname _____

Sex: Male Female Date of Birth _____ Age _____ Soc. Sec. # _____

Street _____ Apt. # _____

City _____ State _____ Zip _____

Home Tel. # (____) _____ Cell Phone # (____) _____

Business Phone # _____ Ext. _____

Dentist _____ Medical Doctor _____

Referred By _____

Driver's Lic. # _____

Nearest relative not living with you _____ Tel. # (____) _____

Have you ever been a patient of our practice? Yes No

Patient: Student: Full Time Part Time Not School Name/Address _____

Married: Divorced Legally Separated Widow Single _____

Employed: Full Time Part Time Retired Not Employer: _____

FINANCIAL POLICY

It is your responsibility to know your insurance coverage and benefits. Please verify your coverage with your insurance carrier prior to any procedure or surgery. All copays and deductibles are to be paid at the time of your surgery. If you have no insurance coverage payment is due at the time of service. A 1.5% interest charge per month will be added to your account for any remaining balance after 60 days. If fees for service are deemed not covered or not medically necessary by your insurance carrier, this statement serves as notice that you will be financially responsible for all fees related to your plan of treatment. If your account is referred to a collection agency you will be responsible for all collection fees, court costs and attorney fees.

I HAVE READ AND UNDERSTAND THE FINANCIAL POLICY OF DR. MICHAEL T. DACHOWSKI, P.C.

X _____
SIGNATURE OF PATIENT OR GUARDIAN (SEAL) DATE

If you have signed the financial policy above, kindly provide the following information about yourself:

Relationship to Patient: ☐ Self ☐ Spouse ☐ Father ☐ Mother ☐ Other

(If Self, skip to next page)

First Name: _____ M.I. _____ Last Name _____

Sex: ☐ Male ☐ Female Date of Birth _____ Age _____ Soc. Sec. # _____

Street _____ Apt. # _____

City _____ State _____ Zip _____

Home Tel. # (____) _____ Cell Phone # (____) _____

Employer _____ Phone # (____) _____



INSURANCE INFORMATION

PRIMARY INSURED PARTY INFORMATION:

Name _____ Relation _____ Soc. Sec. # _____

D.O.B. _____ Home Tel. (____) _____

Street _____ Apt. # _____

City _____ State _____ Zip _____

Employer _____

Tel. (____) _____

PRIMARY DENTAL INSURANCE COMPANY

Ins. Co. Name _____

Insured _____

Employer _____

I.D. # _____

Group # _____

PRIMARY MEDICAL INSURANCE COMPANY

Ins. Co. Name _____

Insured _____

Employer _____

I.D. # _____

Group # _____

ASSIGNMENT OF BENEFITS

I AUTHORIZE PAYMENT OF MEDICAL/DENTAL BENEFITS TO MICHAEL T. DACHOWSKI, D.M.D., P.C. FOR SERVICES RENDERED. Your signature on this form attests to the validity and truthfulness of your answers.

X _____
INSURED OR AUTHORIZED PERSON _____ DATE _____

PRIVACY POLICY

The privacy policy of Dr. Michael T. Dachowski is posted in the reception area. Your signature below confirms your acknowledgement of this policy. If you would like a copy, they are available in the reception area.

X _____
AUTHORIZED PERSON _____ DATE _____

RELEASE OF INFORMATION

I authorize the release of medical and/or dental information, letters, radiographs, and photos so that these may be sent to or discussed with health care providers, insurance companies, or institutions that are or will be involved in my care or treatment or the processing of my insurance claim.

X _____
INSURED OR AUTHORIZED PERSON _____ DATE _____

ADVANCED DIRECTIVES

Because we are an outpatient facility we do not honor a "No Code Directive". All life threatening emergencies will be transported to an appropriate hospital.

Please present completed & signed insurance forms to receptionist.