DEVITO DENTAL SOLUTIONS

WELCOME TO OUR PRACTICE

NAME____________________________________ PREFERRED NAME____________________________

DOB____________SSN#____________________CELL#____________________WORK#______________

Emergency Contact Name_________________Number_____________Email______________________

Home address____

Employer_________________________________ How did you hear about us?_____________________

DENTAL INSURANCE: SUBSCRIBER'S NAME AND ADDRESS_______________________________________

Subscriber's DOB__________SSN#________________Employeer________________________________

FINANCIAL POLICY PLEASE READ AND INITIAL:

____I AUTHORIZE THE DENTAL TEAM TO PERFORM THE NECESSARY SERVICES I MAY NEED.

____I UNDERSTAND WHEN THE OFFICE SUMMITS A CLAIM TO MY INSURANCE I AM RESPONSIBLE FOR THE CO-PAYMENT AND DEDUCTIBLE ON THE SERVICES RENDERED AT THE TIME THE ARE PROVIDED. IF FOR ANY REASON YOUR INSURANCE DENIES PAYMENT FOR DENTAL WORK ALREADY PERFORMED I UNDERSTAND I AM RESPONSIBLE FOR THE REMAINING BALANCE.

____WE REQUIRE A CREDIT CARD TO BE KEPT ON FILE FOR ANY REMAINING BALANCE DUE AFTER INSURANCE PAYMENT IS RECEIVED. PLEASE PROVIDE CREDIT CARD INFORMATION BELOW:

CARD#______________________________________EXPIRATION________________________________

____I DIRECTLY ASSIGN TO DR. CAROLYN DEVITO TO RELEASE ALL INFORMATION MANUAL OR ELECTRONICALLY NECESSARY TO SECURE PAYMENTS OF BENEFITS.

____I HAVE BEEN NOTIFIED OF THE PRIVACY POLICY OF THIS OFFICE AND UNDERSTAND THAT A COPY IS AVAILABLE UPON MY REQUEST.

____I GRANT PERMISSION TO THE DENTAL PRACTICE TO UPLOAD AND STORE CONFIDENTIAL PATIENT INFORMATION (INCLUDINGACCOUNT INFORMATION, APPOINTMENT, AND CLINICAL INFORMATION) TO THE SECURE WEB SITE FOR THE DENTAL PRACTICE. I UNDERSTAND THAT FOR THE SECURITY PURPOSESTHE SITE REQUIRES USER AND PASSWORD TO ACCESS AND USE

PATIENT OR GUARDIAN SIGNATURE/DATE:____