

Dear Valued Patient:

We have prepared this letter to help you understand the complexities of dental insurance, realizing how confusing it can be. To begin, we would like to highlight a misconception dental insurance was not designed to pay for all dental care. Most contracts have limits and/or various degrees of co-payment.

All levels of payment by insurance companies, including allowed fees, usual and customary (UCR), are governed by the premiums paid. They have nothing to do with the actual charges. Our fees are based upon a combination of our cost, our time, and our constant dedication to supplying our patients with the highest quality dental care. The treatment recommended by our office is never based on what your insurance company will pay; your treatment should not be governed by your insurance contract.

However, it should be understood, that the dental insurance contract is between the insurance company and the patient, whom bears the ultimate financial responsibility.

We hope this information has been helpful. Please take the time to review your contract thoroughly so we may best serve you. As always, you may feel free to ask any member of our staff for clarification on services, billing, and insurance.

Sincerely,

Dr. Oleg Z. Cherezov

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Signature

Patient or responsible party

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Print

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Date

## DENTAL INSURANCE INFORMATION

Print Full Name: \_\_\_\_\_ Date: \_\_\_\_\_

### PRIMARY INSURANCE

Dental Insurance Co.: \_\_\_\_\_ Contract #: \_\_\_\_\_

Whose Name Is Insurance In: \_\_\_\_\_

Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Phone: \_\_\_\_\_

### SECONDARY INSURANCE

Dental Insurance Co.: \_\_\_\_\_ Contract #: \_\_\_\_\_

Whose Name Is Insurance In: \_\_\_\_\_

Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Phone: \_\_\_\_\_

**PATIENT INFORMATION**

Date: \_\_\_\_\_

NAME (Last, First, Middle): \_\_\_\_\_ TITLE: \_\_\_\_\_

HOME ADDRESS: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

CITY & ZIP: \_\_\_\_\_ SSN: \_\_\_\_-\_\_\_\_-\_\_\_\_

HOME PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

EMAIL: \_\_\_\_\_

MARITAL STATUS:  Single  Married  Divorced  Widowed SEX:  Male  Female

DRIVER'S LICENSE #: \_\_\_\_\_ STATE: \_\_\_\_\_

**MAILING ADDRESS IF DIFFERENT FROM ABOVE**

ADDRESS: \_\_\_\_\_ / P.O. BOX: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

**SPOUSAL INFORMATION**

NAME: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

EMPLOYER: \_\_\_\_\_ EMPLOYER ADDRESS: \_\_\_\_\_

SSN: \_\_\_\_/\_\_\_\_/\_\_\_\_ DRIVER'S LICENSE #.: \_\_\_\_\_ STATE: \_\_\_\_\_

PHONE/CELL: \_\_\_\_\_

**EMPLOYER INFORMATION**

EMPLOYER: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

EMPLOYER ADDRESS: \_\_\_\_\_

**IF PATIENT IS A MINOR:**

FATHER'S NAME: \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ SSN: \_\_\_\_-\_\_\_\_-\_\_\_\_

ADDRESS: \_\_\_\_\_ HOME PHONE: \_\_\_\_\_

EMPLOYER \_\_\_\_\_ WORK PHONE: \_\_\_\_\_ EXT \_\_\_\_\_

MOTHER'S NAME: \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ SSN: \_\_\_\_-\_\_\_\_-\_\_\_\_

ADDRESS: \_\_\_\_\_ HOME PHONE: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_ EXT \_\_\_\_\_

PERSON FINANCIALLY RESPONSIBLE: \_\_\_\_\_

DRIVER'S LICENSE #: \_\_\_\_\_ STATE: \_\_\_\_\_ SSN: \_\_\_\_-\_\_\_\_-\_\_\_\_

What type of dental problem brought you to our office today? \_\_\_\_\_

\_\_\_\_\_

**HEALTH HISTORY**

Name (last, first, middle): \_\_\_\_\_

Physician: \_\_\_\_\_ Last physical exam: \_\_\_\_/\_\_\_\_/\_\_\_\_

Are you in good health?  Yes  No If no, please explain: \_\_\_\_\_

Are you now or have you recently been under a physician's care?  Yes  No

Reason: \_\_\_\_\_

Do you bleed excessively when cut?  Yes  No

Do you smoke:  Yes  No

Medical alerts: \_\_\_\_\_

Have you ever been told you have periodontal disease?  Yes  No

Please check  each of the following you have had or suspected:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Bypass Surgery          | <input type="checkbox"/> Arthritis           | <input type="checkbox"/> Blood Transfusion        |
| <input type="checkbox"/> Heart Disease           | <input type="checkbox"/> Asthma              | <input type="checkbox"/> Diabetes                 |
| <input type="checkbox"/> Heart Murmur            | <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> Hepatitis or Jaundice    |
| <input type="checkbox"/> Heart Valve Replacement | <input type="checkbox"/> Hay Fever           | <input type="checkbox"/> HIV or AIDS              |
| <input type="checkbox"/> High Blood Pressure     | <input type="checkbox"/> Cancer or Tumor     | <input type="checkbox"/> Kidney / Bladder Disease |
| <input type="checkbox"/> Low Blood Pressure      | <input type="checkbox"/> Radiation treatment | <input type="checkbox"/> Liver Disease            |
| <input type="checkbox"/> Mitral Valve Prolapse   | <input type="checkbox"/> Osteoporosis        | <input type="checkbox"/> Pace Maker               |
| <input type="checkbox"/> Stroke                  | <input type="checkbox"/> Rheumatic fever     | <input type="checkbox"/> Tuberculosis             |

Please check  each of the following that you are taking **or** have taken:

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Actonel        | <input type="checkbox"/> Boniva          | <input type="checkbox"/> Sedatives     |
| <input type="checkbox"/> Anticoagulants | <input type="checkbox"/> Cortisone Drugs | <input type="checkbox"/> Steroids      |
| <input type="checkbox"/> Blood Thinners | <input type="checkbox"/> Fosamax         | <input type="checkbox"/> Tranquilizers |

Please check  each you are allergic to, or have ill effects from:

- |  |   |                                |
|--|---|--------------------------------|
| <input type="checkbox"/> Aspirin           | <input type="checkbox"/> Household Bleach | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Codeine           | <input type="checkbox"/> Penicillin       | <input type="checkbox"/> Other |
| <input type="checkbox"/> Dental Anesthesia | <input type="checkbox"/> Strawberry       |                                |

Are you taking any other medications?  Yes  No

Explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PERSON TO CONTACT IN CASE OF EMERGENCY:**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

**WOMEN ONLY:**

Are you pregnant?  Yes  No If yes, how many months? \_\_\_\_\_

Are you breastfeeding?  Yes  No

Are you taking any birth control medication?  Yes  No

**I consent to the dental procedures and anesthetics necessary for treatment described and agreed to.**

**I accept full responsibility for all treatment rendered.**

\_\_\_\_\_  
Signature  
Patient or responsible part

\_\_\_\_\_  
Print

\_\_\_\_\_  
Date

*This practice is aware of the unfortunate reality of Medical Identity Theft in our society. Our procedures will reflect the current standards required by the Federal Trade Commission in verifying your identity. If your identification has been stolen, please do advise us so we can prevent any possible compromise to your identity.*

*Our purpose is to have you leaving here with a smile 😊*

**Financial Policy**

To our Valued Patient,

In order to keep our fees from rising and keep up with the monumental expenses of bookkeeping and billing services, we have opted to offer our patients new payment policies. This will help reduce our overhead, thus passing the savings along to our patients by being able to maintain our current fee schedule.

1. In order to keep billing to a minimum, we ask that payment for services be made **at the time of visit, unless previous financial arrangements have been made.** The entire cost is incurred on the first visit for services requiring lab work, such as: crowns, bridges, dentures, partials, occlusal guards etc., and must be paid in full before cementation. Payments may be made by cash, check, credit card or through our financial company for easy monthly payments (credit approval is required).
2. Custom made items such as crowns, bridges, partials, etc., take more than one appointment. In the event a patient does not come in for the completion of their treatment **payment in full is still due.**

3. Patients having dental insurance will be asked to pay their deductible and estimated portion of the fee at the time services are rendered and will also be responsible for any balance remaining after the insurance company has paid the claim.
4. While the filing of insurance claims is a courtesy that we extend to our patients, we must emphasize that as dental providers, our relationship is with the patient, not the insurance company. If we do not receive payment from your insurance company within 60 days, payment becomes your responsibility.
5. Unpaid accounts will not be held over 60 days and will be turned over for collections without notice.
6. Time is set aside specifically for you when you make an appointment. Therefore, a minimum of **2 business days** notification is required if you are unable to keep your appointment. Patients canceling without a 2 business day notice or who do not show up for their appointment will be charged a broken appointment fee of \$50.<sup>00</sup>. \_\_\_\_\_ please initial. **Cancellations left on our voice mail service after hours will not be accepted if within this 2 business day requirement.**

I authorize release of any information relating to my dental care. I understand that I am responsible for all costs of dental treatment. I hereby authorize payment directly to the above named dentist of the group insurance benefits otherwise payable to me.

I agree to pay all cost of collections for any outstanding amounts to my account including a reasonable attorney fee. I understand this may increase my outstanding charges by 33 1/3 % \_\_\_\_\_ please initial.

I have read the above financial policies and agree to abide by them.

Method of payment (check all that apply):  Insurance  Cash  VISA  Master Card  Care Credit  
 Chase Credit  Check (verifiable on day of visit)

\_\_\_\_\_  
 Signature of Patient or responsible party

\_\_\_\_\_  
 Print

\_\_\_\_\_  
 Date

## NOTICE OF PRIVACY PRACTICES

As a patient, you have the right to:

1. Tell us the preferred way to contact you to ensure your privacy.
2. Ask us to limit the ways we use your information.
3. Find out: How your information will be used.
4. File a complaint if you feel your privacy rights have been violated.
5. View your medical records and get copies if needed.

