Welcome

Today's Date _____

Name _____ I prefer to be called _____

Address _____

Birthdate _____ Sex: M F Please circle one: Single Married Other

SSN _____ Driver's License Number _____

Home # _____ Cell # _____ Work # _____

Your Employer _____ Email Address _____

Spouse's Name _____ DOB _____ SSN _____

Employer _____ Work # _____ Cell # _____

Responsible Party _____ Driver's license #_____ SSN _____

Address_____ Birthdate_____ Phone #_____

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

Emergency Contact (Name, Address, & Telephone)

_____

Dental Insurance Information
Primary Carrier
Subscriber's Name _____ DOB _____

Ins Company Name _____ Address _____

Phone # _____ Group # _____ Subscriber's # _____

Secondary Carrier
Subscriber's Name _____ DOB _____

Ins Company Name _____ Address _____

Phone # _____ Group # _____ Subscriber's # _____

Consent for Services

Welcome! Thank you for joining us in caring for your dental health. The following is an explanation of our office policies. Please read them carefully and feel free to ask any questions, as we want to prevent any confusion or misunderstanding. We look forward to a long and successful relationship with you in providing optimal dental care.

We ask that you make payment in full at each visit. If you have dental insurance, we ask that you pay for that portion which your insurance does not cover. We accept Cash, Checks, Visa or MasterCard.

Outstanding account balances are due in full within 30 days of service. Accounts over 60 days past due will be turned over to a collection agency and a $20 fee will be assessed. There will be a $20 charge for any returned checks.

We request 48 hours notice for cancellations. If less than 48 hours notice is given, or if appointments are broken (patient does not show up), we reserve the right to charge a fee of $50 or more, depending on the planned appointment length.

We offer financing for patients with treatment plans exceeding $1,000.

Our office will help prepare your insurance forms and assist in collecting from your insurance company. However, we cannot render services on the assumption that our charges will be paid by your insurance company. Therefore, you are responsible for any balance remaining after your insurance pays their portion. We highly encourage you to familiarize yourself with your plan benefits.

I hereby authorize my insurance benefits to be paid directly to Keith Koga D.D.S. I am financially responsible for any balances due and authorize Keith Koga D.D.S. to release any information for this claim. I authorize my records to be used by Keith Koga D.D.S. if he so determines. In consideration of the services rendered to me by this dental office, I am obligated to pay said office in accordance with its credit terms and policies. I consent to photographs and x-rays before, during and after treatment, and to use of the same by Keith Koga D.D.S. in scientific papers or demonstrations.

I have read and consent to the above conditions of treatment and payment. I have read and consent to the HIPPA guidelines.

_____ Date _____ Relationship to patient _____