Diana Kolokowsky DDS
Family & Cosmetic Dentistry

Today's Date: ___/____/_____

How did you hear of our office? _____ Social Security #: _____-_____-_____

Employer: _____ Occupation: _____

Patient's Name: _____ Birth date: _____/_____/_____

Address: _____ City: _____ State: ____ Zip: _____

What would be the best phone number to reach you?: ☐ Home ☐ Work ☐ Cell

Number : (_____) _____ -_____ Email:_____

In case of Emergency, whom shall we notify ?
Name: _____ Relationship:_____ Number : (_____) _____ -_____

InsuranceInformation: (PolicyHolder):

Social Security #: _____-_____-_____ Member ID # _____ Group #: _____

Policy Holder's Name: _____ Birth date: _____/_____/_____

Employer: _____ Occupation: _____

Welcome, and thank you for choosing our office. Our goal is to serve and provide the absolute best experience and dental care for you. Please take a moment to review the information below regarding your clinical care, financial responsibilities and our scheduling policies. With your consent, this will aid our office in providing the best care for you and your healthy smile.

Assignment and Release:
I hereby authorize my insurance benefits to be paid directly to the dentist. I am financially responsible for any balances due. I authorize the dentist to release any information required for dental claims. I authorize that my records may be used by the dentist. If I am receiving dental hygiene services only, I understand that if any dental or medical problems are discovered during the course of my dental hygiene treatment, I will be referred to the appropriate dental or medical expert for any needed evaluation. In consideration of the service rendered to me by this office, I am obligated to pay said office in accordance with its terms and policy.

Financial Responsibilities:
It is your responsibility to know what is covered under your Dental Insurance Plan. Please note that we will do our best in providing your estimated patient portion for your dental visit. However, we are only providing an estimate provided by your insurance carrier. Dental insurance benefits are a negotiated contract term between your employer and an insurance company. The amount of coverage varies, our dental office does not participate in the negations: therefore, we have no influence as to how much, if any coverage your policy provides. We ask that you are prepared to pay your estimated patient portion for treatment provided on the date of service.

48 Hour Cancellation:
We understand there are situations and emergencies that are unfortunately out of our control of. You may be asked to rescheduled your appointment if you are 15 minutes or more late for your scheduled appointment time. Please note, your appointment time is reserved especially for you, with Dr. Kolokowsky, and/or your Hygienist. We require a 48 hour notice to cancel or reschedule your appointment. This allots time for us to provide the canceled or rescheduled appointment for another family or patient. Appointments rescheduled or canceled without 48 hour notice, will acquire a $50 charge for each hour of your appointment.

I certify that I have read or had read to me the consents of this form.

Signature: _____ Date: _____

dianakdds@gmail.com

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