PATIENT INFORMATION

DATE _____

NAME _____ ☐MARRIED ☐SINGLE ☐MINOR ☐MALE ☐FEMALE
LAST FIRST M

SOCIAL SECURITY # _____

ADDRESS _____
STREET APT. # CITY STATE ZIP

BIRTHDATE _____ TELEPHONE _____
MONTH DAY YEAR HOME WORK CELL E-MAIL

NAME OF EMPLOYER _____ ADDRESS _____

IF FULL TIME STUDENT, SCHOOL NAME _____ GRADE _____

PERSON RESPONSIBLE FOR ACCOUNT - PLEASE CHECK ONE: ☐PATIENT ☐GUARDIAN ☐SPOUSE ☐FATHER ☐MOTHER

INSURANCE INFORMATION

MINOR CHILD - MAY NEED TO COMPLETE BOTH BLOCKS FOR PARENT INFORMATION
ADULTS - COMPLETE PRIMARY INSURED
DUAL COVERAGE? ALSO COMPLETE SECONDARY INSURED

PRIMARY INSURED / IF NO INSURANCE COMPLETE FOR RESPONSIBLE PARTY

LAST FIRST M

STREET CITY STATE ZIP

HOME WORK CELL E-MAIL

BIRTHDATE (MO/DAY/YEAR) RELATIONSHIP TO PATIENT

EMPLOYER DENTAL INS. CO

SS# SUBSCRIBER # GROUP #

SECONDARY INSURED

LAST FIRST M

STREET CITY STATE ZIP

HOME WORK CELL E-MAIL

BIRTHDATE (MO/DAY/YEAR) RELATIONSHIP TO PATIENT

EMPLOYER DENTAL INS. CO

SS# SUBSCRIBER # GROUP #

PERSON TO CONTACT IN CASE OF EMERGENCY

Name _____

Address _____

City/State/ZIP _____

Telephone # _____

AUTHORIZATION

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals by any method, including electronic transfer.

X _____
Patient or Responsible Party

_____
Date State Driver's License #

Has any member of your family ever been treated in our office?
☐Yes ☐No

Whom may we thank for referring you to our office?

_____

METHOD OF PAYMENT

Responsible party currently has an account with this office
☐Yes ☐No

☐Payment in full at each appointment (cash or personal check)

☐Payment in full at each appointment (☐VISA ☐MC ☐OTHER)

Card # _____ Exp. Date _____

☐I wish to discuss the Dental Office's Financial Policy

SERVICE CHARGE

If I do not pay the entire new balance within _____ days of the monthly billing date, a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate of _____% per month (or a minimum charge of $_____ for a balance under $_____) which is an annual percentage rate of _____% applied to the last month's balance. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

Dr. John Kazanowski

31700 Telegraph Rd. Ste:100

Bingham Farms, Michigan 48025

248-433-6000

Financial Policy

At Dr. Kazanowski' s office our goal is to provide patients with the highest dental care in a relaxed, comfortable and friendly environment. Before proceeding with any treatment all fees and financial arrangements will be discussed with you and your questions will be answered. Dental treatment is an important decision and we want to ensure that you understand all aspects of your individual treatment plan. Please take a moment to familiarize yourself with our financial policy.

As a courtesy to our patients with dental insurance benefits, our office will submit your insurance claims for treatment and ESTIMATES your co-payment amounts based on the insurance breakdown quoted to us by your insurance company. It is our policy that all patients pay their portion of all fees at the time treatment is rendered. This portion depends on your individual insurance policy. In order to assist you with the investment in your dental health, you may select from the following payment options: Cash, personal check, money order, credit/debit cards: We accept VISA, MASTERCARD, DISCOVER, AMERICAN EXPRESS and CARE CREDIT.

The agreement of the insurance company to assist in paying for dental care is a contract between you (the employee) and the insurance company; therefore, ultimately, you are responsible for payment of all fees for dental care rendered by our office.

I have read and understand the financial policy of Dr. John Kazanowski financial Policy.

_____ Date _____

Signature of Patient, Parent or Guardian

I understand that, under the HIPPA ACT of 1996, I have certain rights to privacy regarding my health information. (Privacy Notice information is available upon request.)

Patient Signature Date