PATIENT INFORMATION

Patient Name ________________________________Preferred name _______________ Birthdate _________

Sex____Marital Status_____SSN (required unless total fee paid in full at each visit)_____________________

Home address____

City/State______________________________Zip__________________Home phone_____________________

Employer______________________________Work phone__________________May we call you at work?____

Email address___________________________ Cell Phone___________________

Preferred method of contact: Home phone _____ Work phone _____ Email ______ Cell phone _____

Student_______Where?_______________ Whom may we thank for this referral?_________________________

Nearest relative *not living with you*__________________relationship____________phone #________________

Guarantor (if not same as above) - Please note: we cannot bill a non-custodial parent

Name____Relationship_____________________

Birthdate_____________ SSN (required unless total fee paid in full at each visit)__________________________

Billing Address____

City/State______________________________Zip__________________Home phone#____________________

Employer______________________________Work phone__________________May we call you at work?____

Insurance	**Primary**	**Secondary**
Insurance Co. Name	________________________________	________________________________
Billing Address	________________________________	________________________________
Telephone	________________________________	________________________________
Group #	________________________________	________________________________
Policyholder's name	________________________________	________________________________
Policyholders ID #	________________________________	________________________________
Relationship to Patient	________________________________	________________________________
Policyholder's Birthdate	________________________________	________________________________
Policyholder's Employer	________________________________	________________________________

I hereby authorize Dr. Lyashenko to furnish information to insurance carriers concerning my dental condition and treatments and I hereby assign to them all payments for dental services to myself or my dependents. I understand that I am responsible for all fees regardless of insurance coverage.

Policyholder Signature _____________________________________ Date _____________________

Policyholder Signature _____________________________________ Date _____________________

(Please turn page over)

Financial Agreement

Patient Name: ___________________________________

Our office believes that part of a successful dental treatment plan is a clear mutual understanding of the costs involved and the payment terms expected. We will make every attempt to let each patient know the costs of treatment prior to beginning dental care with us, however, do be aware that treatment can occasionally change from what was originally planned. Please ask if you are at any point unsure of your financial obligation.

PAYMENT IS DUE ON THE DATE OF SERVICE BY CASH, CHECK, OR MAJOR BANKCARD.

Our office also offers financing options through CareCredit®, a third-party program especially designed for the needs of dental patients. Should you be interested, the financial administrator can review this plan with you and show you how you can apply. This needs to be done prior to scheduling treatment.

Finance charges (18% /APR) are assessed on all account balances over ninety days and are not waived for reasons of untimely insurance settlements. The patient understands that unpaid accounts may be assigned to a credit reporting collection service.

DENTAL INSURANCE

Should you have dental insurance, as a service to you we will file insurance claims on your behalf and we will try to help you estimate what your benefit reimbursement will be. Please be aware that most dental insurance plans are designed to cover primarily only dental health maintenance due to their annual benefit limitations.

Estimated insurance benefits are **ESTIMATES** only and are not a guarantee of coverage. Patients are encouraged to contact their insurance carrier and familiarize themselves with the limits and provisions of their policy. The patient should always bring current insurance information with them to their appointment.

Ultimately, the patient is responsible for timely payment of all dental fees, regardless of coverage limitations. The patient understands that dental insurance is a contract between them and their insurance carrier, and that Dr. Lyashenko is not party to this contract. You will receive a monthly statement even if claims are outstanding. If insurance has not paid within sixty days, the patient agrees to pay the full balance. Any insurance benefits subsequently allowed will be reimbursed to the patient.

MISSED APPOINTMENTS

The doctor reserves appointment times exclusively with each patient. We are committed to being here to serve you and ask that you honor your commitment to us as well. The office reserves the right to charge a missed appointment fee for repeated short notice cancellations.

I hereby authorize the doctor to take x-rays or other diagnostic aids deemed appropriate to make a thorough diagnosis. I give permission for Doctor to share these records with other professionals for teaching/consulting purposes. I authorize Doctor to perform treatments that are indicated.

I have read the financial agreement above and I understand and agree to abide by the terms of this agreement.

_______________________________________ ____________________

Signature of Financially Responsible Party Date