WELCOME TO KENNETH M. SIROCKY, DDS

PATIENT INFORMATION RECORD

Please Print Date:_____

PATIENT

Name_____ Female◯ Male◯

Nickname_____ If Minor-Parent's Names_____

Address_____City_____Zip_____

Home Phone_____ Work_____ Cell_____

Birthdate_____ Age_____ Marital Status: Single◯ Married◯ Divorced◯ Widowed◯

Email Address_____ Social Security Number_____

Who is responsible for payment of this account?_____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?_____

Emergency Contact_____ Relationship_____ Phone_____

DENTAL INSURANCE INFORMATION

Name of Primary Insurance Company_____

Address_____ Phone_____

Name of Policy Holder_____ Policy Holder's Birthdate_____

Relationship to Policy Holder: Self◯ Spouse◯ Child◯ Other_____

Policy Holder's ID/SS#_____ Group #_____

Policy Holder's Employer_____ Employer's address_____

Name of Secondary Insurance Company_____

Address_____ Phone_____

Name of Policy Holder_____ Policy Holder's Birthdate_____

Relationship to Policy Holder: Self◯ Spouse◯ Child◯ Other_____

Policy Holder's ID/SS#_____ Group #_____

Policy Holder's Employer_____ Employer's address_____

(over)

FINANCIAL GUIDELINES

At Kenneth M. Sirocky, DDS we are committed to providing you with the best care possible to achieve total oral health. In order to achieve these goals, we need your assistance and your understanding of our financial guidelines.

INSURANCE

We accept most major dental insurance payments, however, we may not be an in network provider for your plan. If we are not an in network provider, review your dental plan details as reimbursement may vary.

** **No estimate is a guarantee of payment.** I understand that I am responsible for all charges not paid by my insurance. Also, many insurance companies are excluding certain dental procedures or downgrading procedures to a lesser reimbursement level; in which case, I would be responsible for the difference.

****Deductibles & Copayment amounts.** Most dental deductibles are either $25 or $50 with most insurance companies. Our office will ask for a deductible and/or co-poayment amount per visit depending on the amount of treatment that was completed.

****Minors must be accompanied by a parent or responsible adult.** If parents are separated or divorced, I understand that the person accompanying the minor will be responsible for the copayment at the time of service.

PAYMENTS

Patient portion and dental lab bills are due at the time services are rendered unless **prior** financial agreements have been made.

Payment Options

** All major credit cards are accepted (Visa, Mastercard, Discover)
** Financing option available with CareCredit

Temporary financial problems may affect timely payment of your account. If such problems arise, we encourage you to contact us promptly for assistance in the management of your account.

CANCELLATION POLICY

I understand that I need to give 24 hours' notice if I am unable to keep my reserved appointment. Unless an emergency occurs, we expect to run on time for your appointment, and we appreciate the same courtesy from you.

I understand missed appointments cancelled with less than 24 hours' notice are subject to a $25 fee. (initial)_____

By signing below, I acknowledge I have read and understand the guidelines above.

Signature of Patient, Parent or Guardian:_____ **Date**_____

(over for HIPPA)

PATIENT CONSENT FORM

Kenneth M. Sirocky, D.D.S., Inc.
16360 Pearl Road
Strongsville, Ohio 44136
(440) 238-2298

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to :

* Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
* Obtain payment from third-party payers
* Conduct normal healthcare operations such as quality assessments and physician certifications

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name:_____

Signature:_____

Relationship to Patient:_____

Date:_____