Dr Patrick J. Piovesan
Family & Cosmetic Dentistry

Patient Information

Patient Name: Last	First	MI	Date:

☐Male ☐ Female ☐Married ☐Single ☐Child ☐Other

If student, School/College	City	State	Full time?

Social Security#:	Birth date:

Phone(Home):	(Work):	Ext	Cell Phone:

Patient or Parent/Guardian Employer:

Business Address:

Preferred appointment times: ☐ Morning ☐Afternoon ☐ Evening ☐ Any Time ☐ M ☐ T ☐ W ☐ TH ☐ F ☐ S

Address: Street	Apt #

City	State	Zip Code

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient, friend ☐ Another patient, relative
☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ Internet ☐ School ☐ Work ☐ Other

Name of person or office referring you to our practice :

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name:

☐Male ☐ Female ☐Married ☐Single ☐Child ☐Other

Social Security#:	Birth date:

Phone(Home):	(Work):	Ext	Cell phone:

Address: Street	Apt #

City	State	Zip Code

Emergency Contact Information

Name:		Relationship to Patient:
Address:	Phone (H)	(W)

Insurance Information – Please Present Cards

Primary Insurance: Name of Insured:				Is insured a Patient? ☐ yes ☐ no
	Last	First	MI	
Insured's Birth Date:		ID#	Group#	

Insured's Address:			
Street	City	State	Zip Code

Insured's Employer Name and Number:

Patients relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insurance Plan Name and Number:

Dr Patrick J. Piovesan
Family and Cosmetic Dentistry

Insurance Information – Please Present Cards - cont

Secondary Insurance: Name of Insured:				Is insured a Patient? ☐ yes ☐ no
	Last	First	MI	
Insured's Birth Date:		ID#	Group#	

Insured's Address:				
	Street	City	State	Zip Code

Insured's Employer Name and Number:

Patients relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insurance Plan Name and Number:

Consent for Services

We find that communication with our patients concerning financial practices assist us in providing the best possible care. Therefore we have taken this opportunity to inform you of the financial policies of Patrick J. Piovesan D.M.D., P.C.

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursements from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsibility for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patients account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1 ½ % per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of patient examination.

I understand office policy that I must assume financial responsibility for any missed appointments if for cancelling without a 24 hour notice. This fee is, but is not limited to, $50.00.

In consideration for the professional services rendered to, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to the Doctor, or his assignee, at the time said services are rendered, or with five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver if any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you and your assignee, to telephone me at home or ay my place of work to discuss matters related to this form.

I release Dr. Piovesan and his staff to retrieve medical information about myself from previous providers and insurance companies for the purpose of diagnosis and treatment.

I have read the above conditions of treatment and payment and agree to their content.

____ Date: Relationship to patient:
Signature of Patient, parent or guardian

____ Date: Relationship to patient:
Signature of responsible party