Long Island Family Dental, PC
931 Walt Whitman Road

PATIENT INFORMATION

Patient Name _____ Date of Birth _____

Single - Married - Divorced - Separated - Widowed Male/Female

Patient Address _____

Street, Apt # City State Zip

Patient Phone Number _____ Cell Phone _____ Work _____

Social Security # _____ Drivers License # _____

Employer/School _____ Employer/School Phone _____

Employer/School Address _____

Spouse or Parents Name _____

Emergency Contact (name & phone) _____

Name of Primary Insured _____ Relation to Patient _____

Insured Social Security # _____ Date of Birth _____

Insurance Company _____ Phone # _____

Insured Employer & Address _____

Group Number _____

Name of Secondary Insured _____ Relation to Patient _____

Insured Social Security # _____ Date of Birth _____

Insurance Company _____ Phone # _____

Insured Employer & Address _____

Group Number _____

Whom may we thank for referring you? _____

OFFICE FINANCIAL POLICY

Our policy is to provide the best dental care we can provide to our patients. We feel that everyone benefits when office policy and financial arrangements are understood. In order that we may have a complete understanding with regard to the payment for dental services, the following is our office policy:

- Payment is due at time of service. For your convenience we accept cash, check, or major credit cards.
- If you have dental insurance, we will prepare and submit any necessary forms to obtain your benefits. However, ultimately, all fees are the patient's responsibility regardless of insurance reimbursement.
- We provide treatment based on the dental needs of a patient and not on the bases of what your insurance will or will not pay for. It is your responsibility to know the coverage and limitations of your specific policy.
- There will be fees applied to accounts for returned checks or bank fees. Interest charges will be applied to all past due amounts over 60 days. After 90 days your account will be turned over to our lawyers for collections. Charges will be applied to accounts submitted for collections.
- A minimum charge will be made for failed or cancelled appointments without prior notification of 24 hours. Your appointment is time allotted for you. Failed appointments are a waste of the doctors' time and delay the progress of your own treatment and others who could have used that time. Please be courteous with advanced notifications of cancellation and remember that in order to be able to provide prompt service for you and others it is paramount to keep your appointment and be on time.

By signing below, I have carefully read and fully understand all the statements above. I authorize and request my insurance company to pay directly to the dentist. I authorize the doctors to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

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Signature of patient or parent if minor Date