

PATIENT INFORMATION

NAME:	_____	_____	_____	_____
	Last	First	Middle Initial	Preferred Name
SEX:	<input type="checkbox"/> Male	<input type="checkbox"/> Female	STATUS:	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Child <input type="checkbox"/> Other
BIRTHDATE:	____--____--____	SOCIAL SECURITY #: ____--____--____		
ADDRESS:	_____	_____	_____	_____
	Street	City	Cnty	State ZIP
PHONE #:	() ____--____	() ____--____	_____	_____
	Home	Work	Ext.	Cell / Pager
YOUR EMPLOYER:	_____	_____	_____	_____
	Name	Address	Phone #	
IF YOU HAVE DENTAL INS., RELATIONSHIP TO SUBSCRIBER:	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	
NAME OF SUBSCRIBER:	_____	SOCIAL SECURITY #: ____--____--____		
BIRTHDATE:	____-____-____	SUBSCRIBER'S EMPLOYER: _____		
		Name	Phone #	
REFERRED BY (GENERAL DENTIST):	_____			
HAS SOMEONE IN YOUR HOUSEHOLD BEEN SEEN HERE BEFORE?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
IF YES, NAME OF FAMILY MEMBER:	_____			

OFFICE PAYMENT POLICY

PLEASE READ AND SIGN

PATIENTS WITH DENTAL INSURANCE:

The fee for our doctors' services is your responsibility. If you are here for a consult, we ask that you pay the \$50 consult fee today. As a convenience to you, we will help you file your insurance. If you are here for endodontic treatment we will file your insurance, but we do expect your 20% to 50% co-payment at the time of service. Please note that we will keep your insurance outstanding for 45 days from date of service; after that time you are directly responsible for any balance on your account. (See attached insurance policy form for more information).

PREFERRED METHOD OF PAYMENT:

- CASH CHECK CREDIT CARD (MasterCard/Visa *only*)

PATIENTS WITH NO DENTAL INSURANCE:

Payment in full is expected today. We offer no in-house financing; however, we utilize an outside financing agency to assist you with payment arrangements. Please see our front office staff for more information.

PREFERRED METHOD OF PAYMENT:

- CASH CHECK CREDIT CARD (MasterCard/Visa *only*)
 EXTENDED PAYMENT OPTION (Outside agency, must be approved in advance of treatment.)

ALL PATIENTS: An 18% annual (1.5% monthly) finance charge is applied to balances beyond 90 days.

I have read the above information and certify that I am the patient/guardian of the patient and am authorized to furnish the information requested. **I understand that I, not my insurance company, am responsible for payment of the services rendered and that Robert E. Jepko, DDS, PA does not participate in any dental plans.** I further agree to be solely responsible for any collection costs associated with my account.

SIGNATURE: _____ DATE _____