PATIENT INFORMATION

NAME: _____
Last First Middle Initial Preferred Name

SEX: □ Male □ Female STATUS: □ Single □ Married □ Child

BIRTHDATE: _____-- _____ -- _____ **SOCIAL SECURITY #**: _____--_____--_____

ADDRESS:_____
Street City State ZIP

PHONE #: ( ) _____--_____ ( ) _____--_____ _____ ( )_____--_____
Home Work Ext. Cell

YOUR EMPLOYER (NAME & PHONE NUMBER): _____

HAS SOMEONE IN YOUR HOUSEHOLD BEEN A PATIENT HERE PREVIOUSLY? □ Yes □ No
IF YES, NAME AND BIRTHDATE OF FAMILY MEMBER: _____

****GENERAL DENTIST IS****: Referred by (if other specialist):

OFFICE PAYMENT POLICY-- PLEASE READ AND SIGN

PATIENTS WITH DENTAL INSURANCE : **The fee for our doctors' services is your responsibility.** Full payment is expected the day of your appointment for the exam of $50 & CBCT of $95 (if needed) regardless of insurance. As a convenience to you, we will help you file your insurance claim. If you are here for endodontic treatment, we will submit your insurance claim, but **we do expect your estimated portion of your treatment cost today; please ask for our fees.** Knowledge of your insurance coverage is your responsibility and time does not always allow us to obtain this information prior to you being seated and electing treatment.

PREFERRED METHOD OF PAYMENT:

□ CASH □ CHECK (Alamance Co. Residents ONLY) □ CREDIT / DEBIT / HSA

□ CARECREDIT-- **must be approved in advance of treatment**. We offer 6 months interest free.

PATIENTS WITH NO DENTAL INSURANCE: **Payment in full is expected today; please ask for our fees.** We do not accept extended personal payments; however, we utilize an outside financing agency (CareCredit) to assist you with payment arrangements. Please see our front office staff for more information.

PREFERRED METHOD OF PAYMENT:

□ CASH □ CHECK (Alamance Co. Residents ONLY) □ CREDIT / DEBIT / HSA

□ CARECREDIT-- **must be approved in advance of treatment.** We offer 6 months interest free.

ALL PATIENTS: An 18% annual (1.5% monthly) finance charge will be 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 by Robert E. Jepko, DDS, PA.** I further agree to be solely responsible for any collection costs associated with my account.

SIGNATURE: _____ **DATE:**_____