PATIENT INFORMATION

Have YOU been a patient here in the past? □ Yes □ No
Has SOMEONE IN YOUR HOUSEHOLD been a patient here previously? □ Yes □ No

IF YES, Name and birthdate of family member: _____

YOUR NAME: _____
Last First M.I. Preferred Name

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

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

ADDRESS:_____
Street City State ZIP

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

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

OFFICE PAYMENT POLICY-- PLEASE READ AND SIGN

Full payment is expected the day of your appointment for the exam & CBCT regardless of insurance.

PATIENTS WITH DENTAL INSURANCE : **The fee for our doctors' services is your responsibility.** As a convenience to you, we will assist by filing 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. We do our best to obtain an ESTIMATE from your insurance company, but this does NOT guarantee payment from your insurance.

PREFERRED METHOD OF PAYMENT: □ CASH (NO checks) □ CREDIT / DEBIT / HSA / FSA

Must be approved in advance: □ CARECREDIT □ Cherry- please be prepared to make your 1st payment today.

□ I give permission to apply any remaining balance after insurance payments automatically.

PATIENTS WITH NO DENTAL INSURANCE: **Payment in full is expected today; please ask for our fees.**

PREFERRED METHOD OF PAYMENT: □ CASH (NO checks) □ CREDIT / DEBIT / HSA / FSA

Must be approved in advance: □ CARECREDIT □ Cherry- please be prepared to make your 1st payment today.

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:_____