Vondrak DENTAL

EXPERIENCE THE DIFFERENCE OF HEALTH-CENTERED DENTISTRY!

Patient Information

Name: _____

Please Select:

MALE FEMALE MARRIED DIVORCED SINGLE WIDOWED

Home Address: _____

City: _____ **State**: _____ **Zip:** _____

Phone: C _____ H _____ W _____

Email _____ **How do you prefer to be contacted?**_____

Social Security #: _____ **Birth Date:** _____

Emergency Contact: Name_____ Phone:_____

How did you hear about Vondrak Dental? _____

Dental Insurance Information:

POLICY HOLDER Name (*if other than self*): _____

SSN: _____ **Date of Birth:** _____

Employer: _____

Insurance Company:_____**ID#:**_____

Dental Insurance Benefits:

If you have coverage, please have your card available for a photocopy.

I, the patient, understand that when submitting to Dental &/or Medical Insurance, I am still responsible for paying any and all estimated out of pocket fees associated with my services. Vondrak Dental is not responsible for what insurance does or does not pay or the length of time associated with such payments. Vondrak Dental will not submit to Medical Insurance, but would be happy to provide you with the documentation needed for such claim to submit at your leisure.

Signature of patient/responsible party: _____

Dental Treatment for Minors

It is understood that no dental treatment will be performed by Dr. Vondrak, Dr. Rainbolt or staff for any person under the age of 19 without consent of a parent or guardian. We also recommend a parent or guardian be present during a minor's dental treatment. ***Signature of parent/guardian:*** _____

Authorization / Release/ Acknowledgement of receipt of notice of privacy practices:

I authorize Dr. Vondrak, Dr. Rainbolt & Staff to release any information concerning my dental treatment or my child's, to third party payers and/or health practitioners. I have been informed that Vondrak Dental follows the regulations for HIPPA (Health Information Privacy Policies & Procedures) and that this information is available to me upon request.

Signature of patient (or parent/responsible party): _____

I also authorize the release of my PHI to: Name_____ **Relationship**_____

Educational Tools

I give my consent for Dr. Vondrak or Dr. Rainbolt to use any before and after photos and/or models as an educational tool for patients, other doctors and/or advertising purposes.

Signature of patient (parent/guardian): _____