Neighborhood Smiles - Ryan Yakowicz, DDS
120 Greenway Cross Court, Belleville, WI 53508

PATIENT INFORMATION

Thank you for visiting our office! To assist us in serving you, please complete the following confidential form. The information provided is important to your dental health.

Patient's Name _____ Preferred name _____
Birth date_____ Social Security #_____ If minor, parents names _____
Mailing address _____ City _____ State _____
Zip _____
Home phone _____ Cell phone _____ Work phone_____
Other_____

Email address_____
Would you like to receive text/email appointment confirmations and reminders? (Circle One) YES NO

Emergency Contact:
Name_____
Relationship_____ Phone #_____

Whom may we thank for referring you to our office? _____

***INSURANCE INFO*:**
Name of Primary Insurance Company_____
Subscriber name_____ Relationship to patient_____ Birth Date_____
Group #_____ Subscriber #_____
Subscriber employed by_____ Subscriber Social Security #_____
Insurance company address_____
Insurance Phone #_____

Name of Secondary Insurance Company_____
Subscriber name_____ Relationship to patient_____ Birth Date_____
Group #_____ Subscriber #_____
Subscriber employed by_____ Subscriber Social Security #_____
Insurance company address_____
Insurance Phone #_____

☐ I currently DO NOT have any dental insurance

PLEASE COMPLETE BOTH SIDES OF FORM

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APPOINTMENTS:

We value your time, so you can expect us to see you at the appointed time and to keep your time spent in our office as short as possible. In return, when you make an appointment with us please be on time, since we reserved this time just for you. If you must change an appointment, please provide us at least *2 working days advanced notification* so that we may accommodate other patients. We value your time, please value ours.

FINANCIAL POLICY:

At our office, we care about you and your dental health, so we offer choicesfor paying for your dental care. We accept the following forms of payment: Cash, Visa, MasterCard, American Express, Discover, and Third Party Financing (if approved) through Care Credit.

Insurance Policy:

All insurance co-pays and deductibles must be paid at or before the time of service. We will submit all pertinent information electronically to your insurance company and help you to maximize your dental benefits while receiving your personalized dental care. In the event that we do not get payment from the insurance company, the balance will be required to be paid by you.

ACKNOWLEDGEMENTS (please initial):

_____ I authorize my insurance company to pay all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

_____ I authorize the dentist to release all information necessary to secure the payment of benefits.

_____ I understand that I am financially responsible for all charges whether or not paid by insurance.

_____ I have read and acknowledge the above Financial Policy.

_____ Payment is due in full unless prior arrangements have been approved.

SIGNATURE_____ DATE_____

PARENT/RESPONSIBLE PARTY'S SIGNATURE_____

RELATIONSHIP TO PATIENT_____