Dental Implants and Periodontal Health of Rochester

Thomas Zahavi, D.M.D, M.S.

Date: ____________________

Patient Information:

Name: _____________________________ Preferred name: ________________________

Birth date: ___________________________ Social Security #:_______________________

Home Address: ____

City: ________________________ State: __________________ Zip: _________________

Home Phone: (___) ____-________ Cell: (___) ____-________

Email: ______________________ ☐ I would like to receive correspondences via email

Employer: _______________________Referred by: ______________________________

Person to contact in case of emergency: __________________ Phone: ______________

General Dentist: _______________________

Person financially responsible for this account (other than self): ___________________

Dental Insurance Information:

Do you have dental insurance? : ☐ Yes ☐ No

Name of Insured: ____________________ Relationship to patient: __________________

Insurance Company: _________________ Group or Employer Number: ______________

Policy #: ___________________________ Policy Holders D.O.B.: __________________

Insurance CO. Address: ____________________City: ___________ State: ___ Zip_____

Insurance CO Phone: (___) ____-________ Employer: ____________________________

Do you have secondary insurance? ☐ Yes ☐ No

Name of Insured: ____________________ Relationship to patient: __________________

Insurance Company: _________________ Group or Employer Number: ______________

Policy #: ___________________________ Policy Holders D.O.B.: __________________

Insurance CO. Address: ____________________City: ___________ State: ___ Zip_____

Insurance CO Phone: (___) _____-____________Employer: ________________________

OFFICE FINANCIAL POLICY

It is our policy to discuss treatment plans with all patients or guardians before dental treatment is started. A complete estimate of fees and method of payment will be discussed after the initial consultation.

Dental Insurance:

Our office is happy to cooperate with individuals who are covered by dental insurance. We only ask that you carefully read your policy to be sure that you are fully aware of any restrictions that apply to benefits provided. Dental insurance is a contract between the patient and the insurance company. The doctors here at Dental Implants and Periodontal Health of Rochester are a participant with Blue Cross/Blue Choice/Excellus Dental insurance programs.

To prevent any misunderstanding concerning dental insurance payment, the following policy has been established.

1.) Payment must be made as treatment progresses and surgery must be paid in full one week prior to your scheduled date.
2.) We will complete and mail your insurance forms for you. Please keep in mind, however, that you are responsible for payment for services rendered.
3.) A pre-estimate form can be submitted to your insurance company for authorization of benefits prior to treatment being started. Keep in mind that it may take 4-6 weeks for a reply from most insurance companies.

PLEASE NOTE:

Predeterminations are not a guarantee of payment. It is the patient's responsibility to know how much of their yearly benefit is remaining for the year. Most insurance companies have websites for your convenience to access what benefits you have used and have left for the year.

Method of Payment:

1.) Full payment at each appointment is expected in the form of cash, check, credit card (Visa, MasterCard, Discover, Debit, American Express or Care Credit)
2.) If you would need to make payment arrangements, please see our front desk for information on financing through Care Credit.
3.) Interest charges of 1.5% per month are placed on the account if payment is sixty (60) days past due.

Cancellation Policy:

THERE WILL BE A $125.00 CHARGE FOR ANY SURGICAL APPOINTMENT CANCELLED WITHOUT ONE (1) WEEKS NOTICE. THERE WILL BE A $35.00 CHARGE FOR ANY HYGIENE APPOINTMENT CANCELLED WITHOUT 48 HOUR NOTICE.

I have read and understand my financial responsibility at Dental Implants and Periodontal Health of Rochester. If my account goes past due 90 days, I understand that I will be responsible for any charges associated with collection proceedings.

Patient signature: ________________________ Date: __________________________