KUZDENYI DENTISTRY

PATIENT - INFORMATION

Last Name:_____ First Name:_____

Date of Birth:_____

Address:_____

Home Phone:_____ Cell Phone:_____

Please circle the telephone number where we can best reach you or leave a message

Can we text you or leave a message? YES NO

Email Address:_____

EMERGENCY CONTACT - INFORMATION

Last Name:_____ First Name:_____

Phone Number:_____

ASSIGNMENT AND RELEASE: I authorize release, to my dental benefits plan administrator and the CDA, information in claims submitted electronically. I assign my insurance benefits to be paid directly to Kuzdenyi Dentistry. I understand I am financially responsible for the **PORTION NOT COVERED** by my benefits **at the time of service**. I authorize Kuzdenyi Dentistry to release any information required to process my claim to my insurance company.

_____ _____

Signature of Patient (or guardian) Date

MISSED APPOINTMENTS: We require **48 hours notice** for appointment cancellations. Missed appointments without notice will incur a fee of $50 - $100. It is required for this fee to be paid before any further appointments can be booked.

I have read and understood the Missed appointment Policy of this office.

Name:_____

Signature: _____ Date: _____