

*Sikora Family Dentistry*

Social Security # \_\_\_\_\_

Patient Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_

Preferred Name \_\_\_\_\_ E-Mail \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone( ) \_\_\_\_\_ Cell( ) \_\_\_\_\_

May We Leave a Message at:

Your Home? \_\_\_ Yes \_\_\_ No      Your Cell Phone? \_\_\_ Yes \_\_\_ No

Best Place to confirm appointments \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Marital Status \_\_\_\_\_

Employer \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Work( ) \_\_\_\_\_ Occupation \_\_\_\_\_

May We Leave A Message at Your Work?      Yes \_\_\_\_\_ No \_\_\_\_\_

Emergency Contact Name \_\_\_\_\_ Phone # \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Who may we speak to regarding your dental care? List Name(s) Relationship

1. \_\_\_\_\_

2. \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

**Dental Insurance/Subscriber Information**

Primary Insurance \_\_\_\_\_ ID # \_\_\_\_\_

Group # \_\_\_\_\_ Subscriber's Name \_\_\_\_\_

Subscriber's SS# \_\_\_\_\_ Subscriber's Birthdate \_\_\_\_\_

Employer \_\_\_\_\_ Patient Relationship to Subscriber \_\_\_\_\_

Secondary Insurance \_\_\_\_\_ ID# \_\_\_\_\_

Group# \_\_\_\_\_ Subscriber's Birthdate \_\_\_\_\_

Subscriber's SS# \_\_\_\_\_ Subscriber's Name \_\_\_\_\_

Employer \_\_\_\_\_ Patient Relationship to Subscriber \_\_\_\_\_

**PLEASE READ CAREFULLY AND SIGN**

I have received Patient Rights and Notice of Privacy Practices (HIPPA) and if applicable I authorize the release of any dental information necessary to process this bill to my insurance company, I request payment of benefits to SFD. I acknowledge that I am financially responsible for payment whether or not covered by insurance. I also understand that a **48 hour notice** is required to cancel an appointment. Failure to do so will result in a **\$50.00 per hour** cancellation fee.

Signature \_\_\_\_\_ Date \_\_\_\_\_