Sikora Family Dentistry

23755 Lorain Rd
North Olmsted, Ohio 44070
440-779-8730
www.drsikora.com

PATIENT INFORMATION

Patient Last Name _____
First Name _____MI___
Preferred Name _____
Email _____
Address_____
City_____
State _____ Zip _____
Home ( ) _____
Cell ( ) _____
Social Security #_____
Date of Birth _____ Age _____
Marital Status_____
If Married, Spouse's Name_____

Employer_____
Address_____
City_____
State _____Zip _____
Work ( ) _____
Occupation _____

May We Leave at Message at (Circle)
Work: Yes/No Home: Yes/No Cell: Yes/No

May We Confirm Appointments via (Circle)
Text Yes/No Email Yes/No Home Yes/No

Emergency Contact _____
Phone #_____
Relationship to patient_____
Who may we speak to regarding your dental care?
List Name(s) Relationship:

1. _____
2. _____

How did you hear about us? _____
Other Family Members in This Practice
_____

PRIMARY DENTAL INSURANCE

Please Present Insurance Card to be Photocopied
Subscriber Name_____
ID #_____
Subscriber's SS#_____
Subscriber's Birthdate_____
Employer _____
Insurance Company_____
Insurance Group #_____
Address_____
State _____Zip_____
Insurance Phone_____
Patient Relationship to Subscriber_____

SECONDARY DENTAL INSURANCE

Subscriber Name_____
ID #_____
Subscriber's SS# _____
Subscriber's Birthdate _____
Employer _____
Insurance Company _____
Insurance Group #_____
Address_____
State _____Zip _____
Insurance Phone _____
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_____