Please fill out **completely**.
We will be happy to assist you.

Patient Information (CONFIDENTIAL)

Full Name:_____ Birthdate:_____ Soc Sec #_____
Address:_____ City:_____ State: _____ Zip:_____
Home Phone: _____ Work Phone:_____ Cell Phone: _____
Msg # _____ Is it OK if we contact you at work? ☐Yes ☐No
E-mail address _____
Check Appropriate Box: ☐Minor/Child ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated

Patient's Employer: _____ Occupation:_____

Spouse's Name: _____ Employer: _____ Work Phone: _____
Person to contact in Case of Emergency: _____ Phone #: _____

Responsible Party (if other than above)

Name of Person Responsible for this Account: _____ Relationship to Patient: _____
Address: _____ Soc Sec #: _____ Home Phone: _____
Birthdate: _____ Occupation: _____ Work Phone: _____
Employer: _____ Address:_____ Msg Phone:_____
Is this Person Currently a Patient in our Office? ☐Yes ☐No

Insurance Information: Do you have Dental Insurance? ☐Yes ☐No

Name of Insured: _____ Relationship to Patient: _____
Insured's Birthdate: _____ Insured's Social Security Number: _____ Date Employed: _____
Name of Employer:_____ Work Phone: _____

Insurance Company: _____ Group#: _____ Union or Local: _____

Do you have any ADDITIONAL Dental Insurance? ☐Yes ☐No

Name of Insured: _____ Relationship to Patient: _____
Insured's Birthdate: _____ Insured's Social Security Number: _____ Date Employed: _____
Name of Employer:_____ Work Phone: _____

Insurance Company: _____ Group#: _____ Union or Local: _____

(Over Please)

Who may we thank for referring you? _____ Phone: _____

What is the reason for today's visit? _____

_____

Date of your last dental visit: _____

Name of former Dentist: _____ Phone: _____

Authorization Release:

I request Dr. Kautsky to provide dental care for myself, my child, and/or my dependant. I authorize his office to release any dental records to third party payors and/or other health practitioners. I understand that insurance carriers may pay directly to Dr. Kautsky. I understand that dental benefits and my patient portion are estimated and my dental insurance may change, have special clauses or waiting periods. I understand that my insurance may pay less than estimated, or it may pay nothing at all. I agree to be responsible for payment of all services rendered on my behalf or my dependents behalf, regardless of insurance.

X _____ **Date:** _____

Signature of patient or parent if minor

Financial Arrangements

We reserve appointment time just for you. If you are unable to keep the appointment you have made, please notify us immediately! You will be charged if you do not give us 24 hours notice.

Any remaining balance accrues finance charges after 120 days. If entire new balance is not paid within 120 days of the monthly billing date a finance charge of 1%, with a minimum charge of $0.50, on the balance then unpaid and owed will be assessed each month. I realize that failure to keep this account current may result in Dr. Kautsky being unable to provide additional dental services except for dental emergencies. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred.

X _____ **Date:** _____

Signature of patient or parent if minor

Thank you for filling out this form completely. The information you have provided will help us serve your dental healthcare needs more effectively and efficiently.
If you have any questions at anytime, please ask—we are always happy to help.