FRANK KUROWSKI, DDS, PSC
Dentistry *for people who value their health.*

New Patient Information 2019

Today's Date: _____

Name: _____
Ms. Mrs. Mr. Dr. ____ Last First MI. Suffix

Birth date: _____ Social Sec. #: ____ - ____ - ____ Email: _____
For KASPER Report Inquires

Home address: _____
Street Address Apartment/Condo Number City State Zip

***Cell phone:** _____ Work phone: _____ Ext: _____ Home phone: _____

***How do you prefer to be reminded of your appointments?** ❒Email ❒Text Messaging ❒Mobile ❒Home ❒Work

Employer: _____ Occupation: _____

Who may we thank for referring you? _____

Other family members seen by us: _____

Previous/Present Dentist: _____ Last Visit Date: _____ Last Full Mouth X-rays _____

In case of an emergency, who shall we notify other than your spouse?

Name: _____ Relation: _____

Cell phone: _____ Work phone: _____ Ext: _____ Home phone: _____

Person Responsible for the Account: ❒ Same as above. If different, please complete the following.

Spouse / Parent / Guardian: _____
(Circle one) Ms Mrs. Mr. Dr. Last First MI.

Cell phone: _____ Work phone: _____ Ext: _____ Home phone: _____

Billing address: _____
Street Address Apartment/Condo Number City State Zip

Relationship to Patient: _____

Employer: _____ Occupation: _____

DENTAL THIRD-PARTY PAYERS	Primary Dental Third-Party Payer	Secondary Dental Third-Party Payer
Insurance Co. Name:		
Insurance Co. Address:		
Insurance Co. Phone:		
Group Number:		
Member's Name:		Relation:
Member's Social Security Number:		Member's Birth date:
Member's Identification Number:		

Insured's Employer: ❒ Same as above. _____

Insured's Address: ❒ Same as above. _____

Our office asks for the courtesy of at least a <u>48 hours-notice</u> for missing, canceling or rescheduling an appointment.

Financial Options For Your Oral Therapy

We would like to thank you again for choosing our office for your oral health care and dental needs. Dental treatment is an excellent investment in an individual's medical, aesthetic and psychological well-being. Financial considerations should not be an obstacle to obtaining this important, life-enhancing care. We are always available to answer your questions and/or assist you in any way we can.

We accept cash, personal checks, or credit cards (MasterCard, Visa and Discover Card). As a courtesy, we accept third-party payment for routine preventive care (exams, cleanings and radiographs).

For our patients with a third-party payer commonly called "*dental insurance*": The insurance relationship constitutes an agreement between the carrier and you, the patient. As such, we can make no guarantee of estimated allowance or third-party payment. However, we are happy to assist you in filing the necessary forms for your claims. Please know that we will do everything possible to see that you receive the full allowance from your third party payer, as outlined in the policy you or your employer has chosen.

Financing Options

1 **With application and approval we offer financing through CareCredit®**

a ***Interest-Free "Same As Cash" Credit Line*:** Monthly payments (up to 6 months) interest free, up to $25,000.

b ***Extended Payment Plan*:** For treatment plans $1000 and up; 24-48 months duration; no down payment required; no pre-payment penalty.

Thank you for reading Financial Options and Financing Options. Please let us know if you have any questions or concerns.

Signature:_____ Date:_____

Patient (or Responsible Party)

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