Print Form

Welcome To Our Practice

Chart #_____

Patient Information

PatientName:_____Date:_____
Last First MI

Gender(M/F):_____ Marital Status:_____Birth Date:_____

Social Security #:_____Driver's License #:_____

E-Mail Address:_____

Address:_____
Street Apartment #

_____
City State Zip Code

Phone #s: Home_____Work_____Ext_____

FAX_____Cell_____

Whom may we thank for referring you to our practice? _____

Consent for Services, Patient Responsibility for Fees And Assignment of Insurance Benefits

I certify that I am covered by _____Insurance Co. and I assign directly to Dr. Kratofil all insurance benefits, otherwise payable to me.

I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. Payment is due at the time of service.

I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

I understand that the fee estimate listed for dental care can only be extended for a period of six months from the date of the patient examinations.

I consent to treatment provided by the doctors and staff.

_____Date:_____Relationship to Patient:_____
Signature of patient, parent or guardian

_____Date:_____Relationship to Patient:_____
Signature of guarantor of payment/responsible party