PLEASE COMPLETE ENTIRE INFORMATION SHEET

PATIENT'S NAME_____

CIRCLE ONE: MR. MRS. DR. OTHER_____

IF CHILD PARENT'S NAME_____

MALE/ FEMALE EMAIL_____

SOCIAL SECURITY NUMBER_____ DATE OF BIRTH_____

STREET ADDRESS _____

CITY_____ STATE_____ ZIP_____

CIRCLE PREFERRED PHONE NUMBER:

HOME_____ WORK_____ CELL_____

PHYSICIAN_____PHONE_____

PHARMACY _____PHONE_____

EMPLOYED BY_____

SPOUSE'S NAME_____ SPOUSE EMPLOYED BY_____

SPOUSE'S PHONE NUMBER: WORK_____ CELL_____

INSURED HOLDER'S NAME_____DATE OF BIRTH_____

INSURED HOLDER'S SOCIAL SECURITY NUMBER_____

INSURANCE COMPANY_____GROUP NUMBER _____

INSURANCE PHONE NUMBER _____

PERSON RESPONSIBLE FOR THIS ACCOUNT _____

REFERRED BY_____

INSURANCE & FINANCIAL ARRANGEMENT

OUR OFFICE WILL COMPLETE AND SUBMIT DENTAL INSURANCE FORMS TO THE COMPANY TO ACHIEVE THE MAXIMUM BENEFITS TO WHICH YOU ARE ENTITLED AND WILL WORK DILIGENTLY TO MAKE THIS HAPPEN AS QUICKLY AS POSSIBLE.

PLEASE BE AWARE THAT SOME DENTAL INSURANCE COMPANIES TAKE LONGER THAN OTHERS TO COMPLETE PAYMENT. IF NECESSARY, OUR OFFICE WILL CONTACT THE DENTAL INSURANCE COMPANY, OR WE MAY REQUEST YOUR HELP IN THIS MATTER.

IN MOST CASES, WE CAN BEGIN TREATMENT PRIOR TO RECEIVING AN AUTHORIZATION FROM THE DENTAL INSURANCE COMPANY. HOWEVER, YOU NEED TO UNDERSTAND THAT IN ANY EVENT THE DENTAL INSURANCE COMPANY REFUSES TO PAY FOR TREATMENT OR PART OF TREATMENT, YOU ARE ULTIMATELY RESPONSIBLE FOR ALL FEES. NATURALLY, WE TRY TO PROVIDE YOU WITH OUR ESTIMATE OF THE FEES IN ADVANCE.

IF YOU DO NOT HAVE INSURANCE, FINANCIAL ARRANGEMENTS MUST BE MADE PRIOR TO STARTING TREATMENT.

SIGNATURE _____ **DATE**_____

David Silberman D.D.S. F.A.G.D.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____ , have received a copy of this office's Notice of Privacy Practices.

_____
(Please Print Name)

_____
(Signature)

_____
(Date)

For Office Use only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

Welcome...

Our mission is to provide you with excellent dental care.

Out of respect to our patients we try hard to be on time.
Please arrive for your appointment on time.

PATIENTS WITH DENTAL INSURANCE:
As a courtesy to you, our office will gladly submit your insurance for services rendered. We accept regular dental insurance PPO plans. We may be out of network with some PPO plans but we can still work with them. We do not accept Medicaid or DMO types of insurance plans. Please familiarize yourself with your plan by contacting your insurance company or human resources representative.

PAYMENTS:
We accept cash, check, MasterCard, Visa, American Express and Discover.
As a courtesy, we will gladly provide you with an estimated treatment plan prior to any treatment beginning. Payment of your **estimated** portion is due at the time services are rendered, such as your annual deductible and/or percentage of the treatment not covered by insurance. However, despite this, we cannot guarantee the payment of insurance benefits nor can we provide 100% accuracy of this **estimated** amount since many factors are involved that determine the actual payment of benefits once submitted and processed by your insurance. Should an outstanding balance due result after your insurance processes your claim, you will be financially responsible for any balance due.

BROKEN/MISSED APPOINTMENTS:
We request at least 24 hours notice before canceling or rescheduling an appointment. This lead-time provides us an opportunity to try to schedule patients that may be in pain and need to be seen as soon as possible. You will be charged $35 if we are not notified of a cancellation at least 24 hours before your appointment.

By signing below I verify that I completely understand, agree, and accept the policies outlined above. I further acknowledge that I am responsible for all dental services rendered me and my dependents (if applicable).

PATIENT NAME (print):_____ **DATE:**_____

RESPONSIBLE PARTY SIGNATURE:_____ **RELATIONSHIP TO PATIENT:**_____

DAVID SILBERMAN D.D.S
5264 Beechnut
Houston, TX 77096
713-981-4600

ShortTermBraces.com