52nd Street Dental Clinic

Dr. Glen Chabaylo & Associates

Please Print

Patient's Name ____ Male ☐ Female ☐

Surname Given Names

Address ____

Street/Box City Postal Code

Home Phone ____________________ Cell Phone ____________________ Work Phone ____________________

Email ____

I wish to receive appointment reminders via Text ☐ Email ☐ Phone Call ☐

Birthdate ________________________ Marital Status ______________________________________

Month/Day/Year

Name of Spouse ___________________________________ Spouse's Birthdate ____________________________

Month/Day/Year

Alberta Health Care ____

Physician ____

Guardian

Guardian's Name ____

Surname Father/Guardian Mother/Guardian

Father's Birthdate ___________________________ Mother's Birthdate __________________________________

Month/Day/Year Month/Day/Year

Financial

Person responsible for paying account ____

Name of Primary Insurance ____

Group Policy Number _____________________ Contract Number __________________ Division ________________

Name of Policy Holder ____

Name of Secondary Insurance ____

Group Policy Number _____________________ Contract Number __________________ Division ________________

Name of Policy Holder ____

I consent to the collection, use, retention and disclosure of personal information as is required for my own and dependents dental care.

I authorize release, to my benefits plan administrator and CDA, information contained in claims submitted electronically. I also authorize the communication of information related to the coverage describes to the named Dentist.

Office policy is that services are paid for at each visit as they are performed unless the following is completed.

Our office will ask your insurance company to pay us directly for your dental appointments. Any balance remaining after your insurance company has paid, will be the full responsibility of the patient.

Please take a moment to read the following contract initialing and signing where applicable.

1. I authorize release, to my benefits plan administrator and CDA, information contained in claims submitted electronically. I also authorize the communication of information related to the coverage describes to the named Dentist. ______ Initial

2. I hereby assign my benefits, payable from claims submitted electronically, to Dr. Chabaylo and Associates and authorize payment directly to 52nd Street Dental Clinic. ____ Initial

3. Direct Billing balances are due at the time of service when a response from the insurance company is provided. ________ Initial

4. I hereby agree to allow 52nd Street Dental Clinic to charge my credit card on file for any remaining balance when an immediate response is not available or have a co-pay insurance (2nd dental insurance). A copy of your credit card receipt will be mailed or emailed to you. Phone calls will **NOT** be made before putting charges through on the credit card______ Initial

5. I understand that there will be a $25.00 NSF charge if a payment cannot be processed on my credit card within 5 days of the office receiving my insurance payment. I agree to clear up any outstanding NSF balance and the remaining balance within 10 days of being notified to avoid becoming an immediate collection account. ____ Initial

6. It is my responsibility to contact 52nd Street Dental Clinic with any changes to my credit card such as new expiry date. _______ Initial

Credit card Information

Card # ________________________________ Expiry ________________________________

Cardholder Signature ____

Name on card (print) ____

I give permission for my credit cards to be used for balances remaining for the following members of my family:
____
____

This is to certify that I, the undersigned, consent to the performing of the dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anesthetic as indicated and I will assume responsibility for fees associated with those procedures.

Patient's (Guardian's) Signature ____________________________________ Date ______________________________