WHITE OAK FAMILY DENTISTRY

gentle, quality care for the whole family!

ROBERT J. LUSZCZAK, DDS

Patient Information:

Date: _____

Patient Name: _____
First M.I. Last

Birth Date: _____ Age: _____ Male: _____ Female: _____

Married: _____ Spouse: _____ Single: _____ Separated/Divorced: _____ Widowed: _____

Address: _____

_____

Home #: _____ Cell #:_____ Work #:_____

Email: _____

Occupation: _____ Employer/School: _____

If this appointment is for your child, please complete – Parent/Guardian: _____

Address: _____

Phone # _____

Emergency Contact Name & Phone #: _____ Relationship: _____

Is another family member a patient at our office? ☐Yes ☐No Name: _____

Whom may we thank for referring you? _____

Account Information:

Person Responsible for this account: _____ Relationship to Patient: _____

If different than patient, please provide address & phone #: _____

_____

Dental Insurance Co.: _____ Employer: _____

Subscriber's Name: _____ Group #: _____

DOB: _____ SS/ID #: _____

Secondary Insurance Co.: _____ Employer: _____

Subscriber's Name: _____ Group #: _____

DOB: _____ SS/ID#: _____

Consent for Treatment

I hereby authorize Dr. Luszczak or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I agree to the use of anesthetics, sedatives and other medications as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

Lastly, I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1.5% late charge (18% APR) may be added to my account.

_____ Date: _____

Signature of Patient, Parent/Guardian or Personal Representative

Witness: _____

Insurance Assignment & Release

I certify that I, and/or my dependent(s), have insurance coverage and assign directly to Dr. Luszczak all insurance benefits, if any, otherwise payable for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Dr. Luszczak may use my health care information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____ Date:_____

Signature of Patient, Parent/Guardian or Personal Representative

Electronic Messages

Dr. Bob Luszczak and White Oak Family Dentistry use text messaging and email software to confirm appointments and occasionally send messages regarding other office matters. Your cell phone number and email address will only be used by our office and we will not share this information with anyone else. Please choose below your preference in receiving these messages.

Text messages only _____ Email messages only _____ I would like to receive both the text and email messages _____

Once you start receiving your preferred electronic messages you may opt out at any time. If you prefer to receive your appointment confirmations on a landline, please let us know. Please note we reserve the right to charge for appointments cancelled or broken without 24 hour advance notice.

_____

Initials of Patient/Guardian or Personal Representative