

PATIENT INFORMATION

Welcome to our office. Thank you for trusting us with your dental care.

Please complete the following forms. The information provided is relevant to your dental health.

Patient Name: _____ Date of Birth: _____

Preferred Name: _____ Gender: _____

Home Address: _____ City: _____ State: _____ Zip: _____

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

Carrier (circle one): ATT/Verizon/T-Mobile/Other _____ Preferred method of contact (circle one) home/cell/text/email

Social Security #: _____ Driver's License #: _____ Employer: _____

Spouse's Name: _____ Phone #: _____

Emergency Contact: _____ Emerg. Phone # (other than spouse): _____

Primary Dental Insurance: _____ **Group #:** _____ **Employer:** _____

Subscriber's Name: _____ **Date of Birth:** _____ **ID #:** _____

Secondary Dental Insurance: _____ **Group #:** _____ **Employer:** _____

Subscriber's Name: _____ **Date of Birth:** _____ **ID #:** _____

If you are a new Patient:

Name of previous Dentist: _____ **Date of last visit to Dentist:** _____

Referred to us by: _____

Office Policies:

We ask that you provide us with at least **24 hours notice** if you need to cancel your appointment. We recognize that there are times when urgent situations require last minute appointment cancellations. We reserve time especially for you and strive to provide you the best dental care possible. We appreciate your efforts in giving your dental appointments the priority they need. A **"No Show, Late Cancellation" fee of \$75** may be charged if 24 hours notice is not given. After **3 missed appointments**, we reserve the choice to not preschedule further appointments. You will be added to our short call list and contacted to schedule as last minute openings become available.

I hereby authorize Dr. Skachkov and/or his assignees to contact me at any telephone numbers, including cell phones, provided by me or otherwise obtained by them. An automatic telephone dialing system and prerecorded messages may be used on these devices if necessary.

I authorize treatment and agree to accept full financial responsibility for payment regardless of third-party responsibility or insurance contributions. I hereby authorize my Provider's office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. I authorize the release of any medical/dental information requested by my insurance company. I authorize payment of benefits directly to my Provider's office. Finance charges may be charged to balances over 90 days at the rate of 9% per annum. If my account becomes past due, I agree to pay all attorney fees, court costs, filing fees and process service fees which may be assessed by any collection agency or law firm retained to pursue the matter and for the venue and jurisdiction to be in Skagit County.

I certify that all of the above information is correct and that I have read, understand and agree to the above statements.

Patient Signature: _____ Date: _____