Welcome to our practice!

Daniel J. Strinkoski, D.D.S.
Family Dentistry

Thank you for selecting our Dental Healthcare Team. We ask that you fill out this form completely. Please do not hesitate to ask for assistance. We will be glad to help you!

Patient Information

Patient Name: _____ Date: _____
Last First MI Preferred

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other_____

Social Security #: _____ Birth Date:_____

Phone (H): _____ (W): _____ Ext:_____ Cell: _____ E-mail: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employer: _____ Occupation: _____

Person to contact in case of an emergency: _____ Phone: _____

Whom may we thank for referring you? _____

Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____ Relationship: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other_____

Social Security #: _____ Birth Date: _____

Phone (H): _____ (W): _____

Address: _____
Street Apartment #

_____
City **State** **Zip Code**

Insurance Information

Primary

Name of Insured: _____ Relationship to patient: _____
Last First MI

Insured's Birth Date: _____ SS #: _____ Group #_____

Insured's Employer Name: _____

Insurance Plan Name and Address: _____

_____

Secondary

Name of Insured: _____ Relationship to patient: _____
Last First MI

Insured's Birth Date: _____ SS #: _____ Group # _____

Insured's Employer Name: _____

Insurance Plan Name and Address: _____

_____

Authorization, Release, and Agreement to Pay for Services Rendered

I authorize the dentist to release any information including diagnostic or treatment records to third party payers and/or other health practitioners.

I authorize and hereby request my insurance company to pay directly to the dentist any insurance benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependent.

X_____
Signature of patient or guardian Date

Appointments

Our goal is to provide you with quality dental care and personal attention. When making appointments, please remember that this time is reserved for you. If you find that you are unable to keep a scheduled appointment, kindly give us **24 hours notice**. This will allow us to use this valuable appointment time for another patient. A charge of $25 per half hour will be made to patients who fail to follow this policy. This charge must be settled in advance before another appointment is made.

X_____
Signature of patient or guardian Date