Welcome to Dental Care of Cuba

Thank you for selecting our dental healthcare team. Please fill out this form completely. If you have any questions or concerns, please ask for assistance. We will be glad to help.

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~Patient Information~

Name ____ Date of Birth ____________________

Preferred Name ________________________________ Social Security # (needed for account) _____________________

Home Address____City___________________State_____ Zip_________

Home Phone________________________Work_____________________(ext)______Cell___________________________

Email_______________________________________Do you prefer TEXT, EMAIL or PHONE CALL appointment reminders?

Are you: __a MINOR __SINGLE __MARRIED __DIVORCED __WIDOWED __MALE __FEMALE

Emergency Contact______________________________________Relationship_______________Phone______________

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~Responsible Party~ (If differs from patient information)

Person Responsible for this patient (Appointments and Account)____

Relationship to Patient__________________ Date of Birth__________________Social Security # ____________________

Address ____ Phone________________________

Employer____ Work Phone______________________

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~Insurance Information~

Policy Holder ____ Relationship to Patient_________________________

Employer____ Work Phone__________________________

Date of Birth___________________________Social Security#___________________Date Employed_________________

Insurance Company_____________________________________ID#____________________Group#______________

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~Referral Information~

How did you find our office? (Circle all that apply)

__FRIEND/FAMILY MEMBER __CO-WORKER __PHONEBOOK __INSURANCE __FACEBOOK __OFFICE WEBSITE

__LOCAL BUSINESS __NEWSPAPER __RADIO __DENTAL OFFICE REFERRAL OTHER____________________________

Please list the person or business that referred you so we can thank them.______________________________________

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~Dental History Information~

This questionnaire is designed to help us get to know you better. Please answer the questions in the way that you understand them. There are no right or wrong answers. This information will be kept in your patient file and will be confidential.

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~How would you describe the general condition of your mouth (teeth and gums)?

~Are you experiencing pain at the present time? Please describe.

~What dental needs do you think you have? What would you like for us to do for you at this office?

~Have you had dental care in the past? If so, when was your last visit? What was done at that visit?

~Are you pleased with your smile? Is there anything you would like to change?

~Do you have any concerns about receiving dental treatment that you would like to make us aware of?
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~Please read each section and initial agreement~

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~Consent to Exam and Cleaning~

Responsible Party Initial Here__________

I authorize Dr. Sessler and his associates to perform a dental examination, including exposing x-rays, to take intraoral and facial photos as are deemed necessary to properly diagnose my dental condition and for use as the patient identification. I also consent to having a dental cleaning. (*Please note-in the cases where a filling that is present in your mouth is loose or defective, this filling may become dislodged during a dental examination and/or cleaning*.)

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~Privacy Policy~

Responsible Party Initial Here__________

We are required by law to maintain the privacy of protected health information, to provide individuals with written notice of our legal duties and privacy practices with respect to protected health information and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in the Notice "***Notice of Privacy Practices, Steven R. Sessler DDS, PC***" while it is in effect. This Notice takes effect 2/5/2019, and will remain in effect until we replace it. Please review the copy of the Notice provided to you.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please ask at the front desk or call our office at (585)-968-8400.

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~Authorization and Release~

Responsible Party Initial Here__________

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such dental care to a third party payer and/or other health practitioner, if request initiated by practitioner.

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~Agreement to Pay for Services Rendered and Insurance Authorization~

This agreement is between ____ and ***Steven R. Sessler DDS PC.***

I agree that I am responsible for all charges incurred from my own or my dependent's dental treatment and will pay my bill promptly.

I realize that failure to pay the charges may result in the dentist being unable to provide further treatment except for dental emergencies or where there is prepayment for services. In the case of default on payment, I realize that my account may be referred to a collections agency or to civil court. I furthermore agree to pay collection costs and reasonable attorney fees incurred in attempting to collect a debt.

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

I understand that ***Steven R. Sessler DDS PC*** will bill my insurance as a courtesy and with no additional fees. 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 dependents.

***Signature of Responsible Party*____*Date*________________________**

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~Payment in Full is Required at Each Appointment~

For you convenience we offer the following methods of payment. Please check the option you prefer. If you have questions regarding this policy, please ask for assistance.

__CASH   __PERSONAL CHECK (Return Check Fee $20.00)   __CREDIT/ DEBIT CARD (VISA, MasterCard, Discover, American Exp.)
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~Missed Appointment / Short Notice Cancellation Policy~

A requirement of being a patient of *Steven R. Sessler DDS PC* is that you are dependable for appointments. Your dental health is very important to us and we have dedicated a block of time on our schedule specifically for your care.

Effective 4-15-2013, we will allow one failed appointment to each patient. We do understand that everyone can forget things at times.

If you miss an appointment for the second time without providing adequate notice (24 hours). You will be subject to a missed appointment fee and/or dismissal from the practice if you do not have a documented true emergency.

I have read the above statement and agree to the terms and conditions.

***Signature of Responsible Party*_____*Date*_____**