

Dr. Kevin B. Cebrynski, D.D.S., P.C.

Welcome

Thank you for selecting our dental healthcare team!
We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

Patient Information (CONFIDENTIAL)

Name _____ Title _____ Date _____
Home Phone _____
I prefer to be called _____ Cell Phone _____
Mailing Address _____ City _____ State _____ Zip Code _____
Physical Address _____ City _____ State _____ Zip Code _____
Date of Birth _____ Age _____ SS# _____
If Student, Name of School/College _____ City _____ State _____ Full Time Part Time
Patient's Employer _____ Work Phone _____
Spouse or Parent's Name _____ Employer _____ Work Phone _____
Whom May We Thank for Referring You? _____
Person to Contact in Case of Emergency _____ Phone _____

Responsible Party

Name of person Responsible for this Account _____ Relationship to Patient _____
Mailing Address _____
Physical Address _____
Social Security # _____ Birthdate _____ Drivers License# _____
Employer _____ Address _____ Work Phone _____
Is this Person Currently a Patient in our Office? Yes No Home Phone _____

Insurance Information

Name of Insured _____ Relationship to Patient _____
Social Security # _____ Birthdate _____ Date Employed _____
Name of Employer _____ Union or Local # _____ Work Phone _____
Address of Employer _____ City _____ State _____ Zip _____
Insurance Company _____ Group # _____ Policy/ID # _____
Ins. Co. Address _____ Ins. Co. Phone _____

FEES AND PAYMENTS

(Professional Fees are due at the time of service.)

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. I am aware that pre-authorization and acceptance of submitted dental work to my insurance company is not a guarantee of insurance payment.

I authorize the dentist to release any information, including the diagnosis and the records of any treatment or examination rendered to me or my family, during the period of such Dental care to third party payors and/or health practitioners by mail or electronic transmission, in accordance with the HIPAA Privacy Rule.

I have received and read the Office Policies for Dr. Kevin Cebrynski, D.D.S., and I agree to be responsible for payment of all services and charges in the office of Dr. Kevin Cebrynski rendered on my behalf or for other members of my family.

Patient/Responsible Party Signature _____ Date _____