Heritage Lake Dental

Catherine M. Wong, D.D.S. John Smolnicky, D.D.S.

Date:_____SSN:_____DOB:_____PATIENT NAME:_____

PARENT NAME(if pt is a minor):_____ADDRESS:_____

CITY:_____ST:_____ZIP:_____ Cell___/Other___ #_____

_____ E-MAIL_____

BEST WAY TO CONTACT YOU:_____REFERRED BY:_____

PATIENT/PARENT EMPLOYER:_____POSITION:_____

INSURANCE:_____SUBSCRIBER SSN:_____SUBSCRIBER DOB:_____

I,_____, give my permission to have my photograph or video used for the purpose of marketing for the dental office. I understand that my name will not be used, and will not be sold for any other office use. I also understand that I will not be compensated for the use of my photograph(s) unless otherwise discussed.

ACCEPT ☐ DENY ☐

If you are covered by dental insurance it is important that you are aware of the extent of your coverage. Most insurance companies offer benefits for only a portion of the total services you receive. Payment is due at the time of service. This office is not responsible for your insurance companies delay in payment or non-payment of any services. All charges not paid by insurance are due within 30 days of notification upon non-payment.

Please be prompt for your appointments. A broken appointment fee will be charged at a fee of $65 for any appointments cancelled, missed, or rescheduled with less than 48 hour notice.

I/We hereby authorize the assignment of any insurance benefits to the doctors; and agree to be liable for the payment of all dental and medical services performed and not paid by insurance or other benefits. I/we also agree to pay interest thereon at 1-1/2% per month (18% per annum), on any balances left due and owing.

I/We also agree to pay all collection costs and reasonable attorney fees in the event this account or any future account of mine is turned over to our attorneys for collection, all without relief from valuation and appraisement laws should I/we fail to pay any amounts not paid by insurance or other benefits.

SO AGREED,

PATIENT SIGNATURE:_____DATE:_____

RESPONSIBLE PARTY (IF MINOR):_____DATE:_____