NORMAN MICHAEL TRAHOS, DDS, PLLC

PATIENT INFORMATION

Date _____

Name (first, middle initial, last) _____

Sex: Male_____Female_____

Please check one: Single_____Married____Child_____Other_____

Date of Birth _____Social Security #_____

Address:_____

City:_____State:_____ZipCode_____

Home Phone: (_____)_____

Work Phone: (_____)_____

Cell Phone: (_____)_____

Email: _____

Employer:_____Occupation:_____

Address:_____

Referred by:_____

Name of Dental Insurance:_____

Name of Policy Holder:_____

Social Security #of Employee:_____Date of Birth:_____

Relationship to policy holder: Self_____Spouse_____Parent_____

Policy Holder's Employer_____

Address of Ins. Co:_____

Group number:_____

Phone #of insurance company_____

Individual ID# if different then SS#_____

In case of emergency please list two contacts:

Name_____Relationship_____Phone_____

Name_____Relationship_____Phone_____

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold Dr. Trahos, or any member of the staff responsible for any errors or omissions that I may have made in the completion of this form.

Date_____Signature:_____

(Patient or Guardian)

PATIENT AGREEMENT AND FINANCIAL POLICY

I hereby agree to be responsible for the costs of care provided by Dr. Trahos and/or the dental team for myself or my dependent(s). Payment to this office is my responsibility and I am aware that if the insurance company does not reimburse the doctor I am responsible for the total amount(s).

I understand that because appointments are not double-booked, I must provide notice of cancellation at least 48 hours prior to my scheduled appointment time. **For any missed appointment a fee of thirty-five ($35) dollars will be assessed to my account for every fifteen minutes scheduled.** The fee covers the cost of office overhead during the time set aside specifically for me or for my dependent(s).

We make every effort to schedule appointments that are the most convenient for you and that fit your personal schedule. Because we do not schedule several patients at the same time, all appointments are reserved exclusively for you. In return, we ask that you make every effort not to change your reserved dental appointment.

I understand that for any treatment payment in full is due at the time of service. Any payment plans I agree to with this office must be completed. I understand that failure to pay amounts due to this office will result in may account being placed with a collection agency. In the event that my account is further referred to any attorney I agree to pay all collection and attorney fees.

Date:_____Signature:_____

Signature of Patient/Guardian