Neal A. Zabiegalski, D.D.S., P.C.

PATIENT INFORMATION Date _____

□Mr. □Mrs. □Ms. □Dr. **First Name** _____ M.I. _____ **Last Name** _____

Sex: □Male □Female **Birth Date** _____ Age _____ **SS#** _____ Email _____

Street Address _____ City _____ State _____ Zip _____

Mailing Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Are you a previous patient? □Yes □ No

Referred By _____ Dentist _____ Medical Doctor _____

Driver's Lic. # _____ Notify in case of emergency _____ Phone _____

Employer _____ Address _____ Phone _____

Who will be responsible for your account? □Self □Spouse □Father □Mother □Other _____

Name _____ **SS#** _____ Birth Date _____ Phone _____

Street Address _____ City _____ State _____ Zip _____

Employer _____ Phone _____ Payment Type: □Cash □Check □Visa/MC □CareCredit

INSURANCE INFORMATION

Employed: □Full Time □Part Time □Retired □Not Student: □Full Time □Part Time □Not School_____

Status: □Married □Divorced □Legally Separated □Widow □Single

Primary Insurance Information	**Secondary Insurance Information**
Medical Ins. Co. Name_____	Medical Ins. Co. Name_____
Address _____	Address _____
Group # _____ Policy # _____	Group # _____ Policy # _____
Dental Ins. Co. Name _____	Dental Ins. Co. Name _____
Address _____	Address _____
Group # _____ Policy # _____	Group # _____ Policy # _____
Insured Party _____	**Insured Party** _____
Relation _____ **Date of Birth** _____	Relation _____ **Date of Birth** _____
Employer _____	Employer _____
Address _____	Address _____
Phone_____ **SS#** _____	Phone_____ **SS#** _____

CONSENT FOR EXAMINATION & X-RAYS / INSURANCE AUTHORIZATION & FINANCIAL AGREEMENT

I authorize Dr. Neal Zabiegalski to perform an oral and maxillofacial examination upon _____, for the purpose of diagnosis and treatment planning, and the medical history I have given is correct. Furthermore, I authorize the taking of all x-rays required as a necessary part of this examination. In addition, if medically necessary, I authorize release of any information acquired in the course of my examination or treatment. I hereby assign to the physician all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

If I do not pay the entire new balance within 30 days of the monthly billing date, a late charge of 1.5% will be assessed each month on the unpaid balance. In the case of default on payment of this account, I agree to pay collection and attorney fees incurred in attempting to collect on this amount or any future outstanding balances.

Signature _____ Date _____

Witness _____ Relationship to Patient _____

Neal A. Zabiegalski, D.D.S., P.C.