

Encino Family Dental

Marian Yassa DDS

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Personal Information Form

Date: _____

Please complete this confidential information sheet in its entirety at time of initial visit.

Name _____ Gender: M F Social Security # _____
Last First MI

Drivers License # _____ Birth Date _____ Age _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email: _____

Mailing Address _____ City _____ State _____ Zip _____

Employer and Address _____

Spouse/Parent Name _____ Phone _____ Social Security # _____

Spouse Employer and Address _____

Who may we thank for referring you to our office? _____ Phone _____

IN CASE OF EMERGENCY:

Name and Relationship _____ Phone _____

1. DENTAL INSURANCE (please provide membership card if available)

Name of Insured/Employee _____ Birth date _____
Month/Day/Year

Employer _____ Employee SSN/ID # _____

Insurance Company _____ Policy/Group # _____

Claims Address _____

2. ANY OTHER DENTAL INSURANCE OR MEDICAL INSURANCE

Name of Insured/Employee _____ Birth date _____
Month/Day/Year

Employer _____ Employee SSN/ID # _____

Insurance Company _____ Policy/Group # _____

Claims Address _____

FINANCIAL AGREEMENT:

FULL PAYMENT IS DUE AT THE TIME OF SERVICE

We accept cash, VISA, Mastercard, Discover, American Express, Care Credit and personal check. **There will be a fee of \$25.00 charged on all return checks.**

REGARDING INDEMNITY INSURANCE

Encino Family Dental will process most dental insurance claims as a courtesy to our patients. However, we cannot guarantee that your insurance company will pay the "estimated" figure. The balance is your responsibility whether your insurance company pays or not. Therefore, the balance on the account remains always the sole responsibility of the patient. Your insurance policy is a contract between you and your insurance company. We are not a party within the contract. Please be aware that some and perhaps all of the services provided may be non-covered services under your dental insurance policy. All co-pays and deductibles are due at the time of treatment. Please bring all insurance information and cards to first appointment.

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. All insurance companies are not the same in what they consider to be usual and customary fees. Please be advised that many times insurance companies pay for the least alternative treatment. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. We recommend that you take the time to read over your policy and contact your carrier if you have any questions regarding your coverage.

MINOR PATIENTS

The adult accompanying a minor and the parents/guardian of the minor are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved payment method at the time of service.

BROKEN APPOINTMENTS

We reserve the right to charge a minimum of \$25.00 for any broken appointment or appointment cancelled with less than a 24-hour notice.

INSURANCE RELEASE: I hereby authorize Encino Family Dental to furnish to the above named insurance company all treatment and x-ray information which said insurance company may request. I hereby authorize payment to be made directly to Encino Family Dental but not to exceed the charges incurred.

The undersigned agrees, whether he/she signs as an agent or as a patient, that in consideration of the services to be rendered to the patient: I hereby individually obligate myself to pay the account in accordance with the fees and terms of the Dental Office whether or not they are covered by insurance. Should the account be referred to an attorney for collection for this visit or any other, the undersigned shall pay all reasonable costs and expenses including attorney's fees and collection expense.

Thank you for your understanding of our financial policy. By signing this, I acknowledge that I have read, understand and agree to the terms of this financial policy.

Signature _____ Date _____