



# WELCOME TO NOVA DENTAL STUDIO

Name: \_\_\_\_\_

Last

First

MI

Title

Preferred Name: \_\_\_\_\_

Male  Female

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

SSN: \_\_\_\_\_ DOB: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Marital Status:  Single  Married  Divorced  Widowed  Separated

How did you hear about our office?: \_\_\_\_\_

Do you prefer to be contacted for appointment confirmation via e-mail or phone?: \_\_\_\_\_

## • Insurance – Primary

Subscriber Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Subscriber DOB: \_\_\_\_\_ Subscriber SN/ID: \_\_\_\_\_

Subscriber Employer: \_\_\_\_\_ Insurance Company Name: \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_

Insurance Company Phone: \_\_\_\_\_ Group Number: \_\_\_\_\_

## • Insurance – Secondary

Subscriber Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Subscriber DOB: \_\_\_\_\_ Subscriber SN/ID: \_\_\_\_\_

Subscriber Employer: \_\_\_\_\_ Insurance Company Name: \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_

Insurance Company Phone: \_\_\_\_\_ Group Number: \_\_\_\_\_

## • Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to NOVA Dental Studio all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**CONSENT:** I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care. To avoid a broken appointment charge of \$75 for each hour, or any portion of an hour, with a hygienist, and \$100 for each hour, or any portion of an hour, with Dr. Paesani, PLEASE notify us of a cancellation no less than 24 hours, or one full business day, prior to your appointment. Voicemails left over the weekend will not constitute adequate notice and will result in a broken appointment charge.

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_