Eric T. Moskowitz, DDS
Cosmetic, Implant & General Dentistry

Cannon Crossroads Shopping Center
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PATIENT INFORMATION

Name:				Title:	Dr. Mr. Mrs. Ms
	first	**last**	**mi**		
Date of Birth:		Gender: M F		Marital Status:	Married Single Child Other
Social Security #: required					
Home Address:					
	House No.	Street	City	State	Zip
EMAIL:			May we email you?		Yes/No
HOME PHONE:			May we leave messages?		Yes/No
WORK PHONE:			May we leave messages?		Yes/No
CELL PHONE:			May we text you?		Yes/No
EMER CONTACT:		RELATIONSHIP:		PHONE:	

DENTAL INSURANCE COVERAGE -please fill out in detail

Name of Insured&/or Responsible Party:	DOB:	Social Sec #: required
Relationship to Pt:	Insured ID #:	
Employer:	Insurance Co.	Group no:
Insurance Co. Address:	Insurance Phone no.	

PLEASE INFORM US IF YOU HAVE SECONDARY INSURANCE. IT IS FEDERAL LAW TO FILE APPROPRIATELY.

Please note that the insurance coverage is between you, your employer & the insurance co. We file for pymt on your behalf.

Our office is not responsible for keeping up with waiting periods, deductibles, frequencies, maximums, downcoding * & copays

*Downcoding is when an insurance assigns a different code to a treatment that was done.

If this is done - it is the patients responsibility to pay the difference, as well as, estimated copays & deductibles at the time of service.

We file all insurances. We are in network w/Aetna PPO; BCBSNC; Cigna PPO; Delta Premier; Guardian PPO, Metlife PPO

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES OF ERIC T. MOSKOWITZ, DDS, PA

Notice to Patient: We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use &/or disclose your health information. By signing below, you acknowledge receipt of the Notice. You may refuse to sign this acknowledgement.

I acknowledge that I have received a copy of this office's Notice of Privacy Pratices.

Please print your name above	Signature (parent if patient under 18)	Date

I authorize the dentist/employees to discuss my treatment with the following. I may revoke this at any time in writing.

Name:	Relationship:	Date:
Name:	Relationship:	Date:

FOR OFFICE USE: We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy from this patient but could not due to:

___ Patient refused to sign ____Due to an emergency-it wasn't possible ____Can't communicate: ____Other

FINANCIAL AGREEMENT AND RELEASE:

By initialing each &/or signing below, I authorize the dentist (or dentist's employees) to & understand the following:

____* perform diagnostic procedures & dental treatment as may be necessary for proper dental care & release any information concerning my/my childs care, advice & treatment provided for the purpose of evaluating & administering claims for insurance & other dental specialists.

____* I authorize payment of insurance benefits directly to the dentist & agree to pay all unpaid balances immediately.

____*Understand the estimate given to me is an Estimate & agree to pay any & all balances regardless of estimate or insurance.

____ *I am responsible for & agree to pay the total cost of dental services, regardless of any insurance benefits &/or pymts.

____ *I agree to pay all deductibles & estimated copays on the date of service.I also agree to pay any unpaid balance after insurance

____*Appointment times are reserved exclusively for me. *Any unpaid insurance claim becomes patients balance at the 30th day.

____ *I must confirm appt online or by phone no less than 48 hours in advance to keep from being removed from the schedule.

____ *I am responsible for a fee of $100 for any late cancellations (less than 24 hours)/missed/or no show appts.

***the office accepts Discover, American Express, Mastercard, Visa, Checks & cash. $25 fee for any returned check.**

Thank you for choosing us for your dental needs! Please tell us who we can thank for your visit: _____

SIGNATURE

Patient/ Guardian Signature: **Date:**