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
Soc Sec #: required					
Home Address:					
	House No.	Street	City	State	Zip
EMAIL:				May we email you regarding appt?	Yes/No
HOME PHONE:				May we leave messages regarding appts?	Yes/No
WORK PHONE:				May we leave messages regarding appts?	Yes/No
CELL PHONE:				May we text you regarding appointments?	Yes/No
EMER CONTACT:		RELATIONSHIP:		PHONE:	

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

DENTAL INSURANCE COVERAGE -please fill out in detail

Name of Insured&/or Responsible Party:		DOB: / /	Soc Sec #: required
Relationship to Pt :*Circle 1* SELF SPOUSE CHILD	Insured ID #:		
Employer:	Insurance Co.		Group no:
Insurance Co. Address:		Insurance Phone no.	

PLEASE INFORM US IF YOU HAVE SECONDARY INSURANCE. We do not accept secondary ins as payment. 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

____*The time reserved is exclusively made for me. I must confirm 48 hrs prior to avoid being removed from the schedule.

____*Any unpaid insurance claim becomes patients balance at the 30th day.*Preauth only done upon request for a $25 fee

____ *I am responsible for a fee of $100 for any late cancellations (less than 24 hours)/missed/or no show appts. $200 dep due for 2 hour appts

***We accept Discover, Amer Express, MC, Visa & cash. $25 fee for returned check (if accepted). $50 fee added to account that is turned over to collections.**

SIGNATURE

Patient/ Guardian Signature: **Date:**