JOHN V. REITZ., DDS
30 COMMERCE DRIVE, SUITE 2
READING PA 19610

(610)320-9993

jreitz@reitzdds.com
www.reitzdds.com

Patient Information

Patient's Name and Birthdate

Patient's Address

Name of person, office, or other source referring you to our practice:

Physician's Name, address and phone number

What are the main concerns that you would like to have accomplished?

Have we treated another member of your family?

- ○ Yes
- ○ No

Is there anything that you would like to discuss with the doctor in private?

- ○ Yes
- ○ No

Spouse or Responsible Party Information

Insurance Information
Marital Status

- ☐ Single
- ☐ Married
- ☐ Widowed
- ☐ Divorced
- ☐ Separated
- ☐ Domestic Partner

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The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: ____________________ Phone: __________

Address: ____________________ ____________________

____________________ City ____ State __________ Zip Code

Do you have dental Insurance?

○ Yes ○ No

Insurance Company Name____________________

Insurance Company Phone Number____________________

Group Or Plan____________________

Insurance Company Address:

____

Do you have secondary Insurance?

○ Yes ○ No

Secondary Insurance Company:____________________

Secondary Insurance Phone Number:____________________

Group Or Plan____________________

Secondary Insurance Address:

____

Consent for Services

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As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed unless other arrangements are made.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

☐ I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent, or guardian (responsible party):

Signature: ______________________ Date: [ ]

In Case Of an Emergency Contact (Please Include Phone Number and Relationship to you)

[ ]

Response Date: [ ]

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I acknowledge that I have received the Signature Dental Care Notice of Privacy Practice that describes how my dental and medical information may be used or disclosed as required by federal law.

Signature: ______________________________ Date: [ ]

Permission to Discuss Dental Information

The privacy of your dental and medical information is very important to us. If you wish to discuss information about your medical condition to your family, friends, caregivers, or others, please indicate this by completing the information below.

I, ______________________, permit the discussion of my healthcare information for the purpose of communication results, findings, care decisions and billing/payment information to the following individuals:

______________________________ relationship______________________

______________________________ relationship______________________

Signature____

Date ____________________

Response Date: [ ]