Dr. Steven T. Kobayashi, D.D.S.

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

PERSONAL INFORMATION

TODAY'S DATE: ____________________

NAME ____________________ WISHES TO BE CALLED ____________________

BIRTHDATE ____________________ SS#/SIN ____________________

☐ MINOR ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED

ADDRESS ____________________ SUITE/APT # ____________________

CITY ____________________ STATE/PROV ____________________ ZIP CODE/P.C ____________________

EMPLOYER ____________________ OCCUPATION ____________________

HOME PHONE # ____________________ CELL PHONE # ____________________ WORK PHONE # ____________________ EXT # ________

E-MAIL ADDRESS ____________________

☐ CHECK HERE IF YOU WOULD LIKE US TO CONFIRM YOUR APPOINTMENTS VIA E-MAIL

WHERE DO YOU PREFER TO RECEIVE CALLS: ☐ HOME ☐ CELL ☐ WORK

WHAT IS THE BEST TIME TO REACH YOU: TIME: ____________ DAYS: ____________________

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE: ____________________

IN THE EVENT OF AN EMERGENCY, WHO SHOULD WE CONTACT?

NAME ____________________ RELATIONSHIP TO PATIENT ____________________

HOME PHONE # ____________________ CELL PHONE # ____________________ WORK PHONE # ____________________ EXT # ________

RESPONSIBLE PARTY *Who is responsible for this account?*

NAME ____________________ RELATIONSHIP TO PATIENT ____________________

BIRTHDATE ____________________ SS#/SIN ____________________ DRIVER'S LICENSE # ____________________

ADDRESS ____________________ SUITE/APT # ____________________

CITY ____________________ STATE/PROV ____________________ ZIP CODE/P.C ____________________

EMPLOYER ____________________ OCCUPATION ____________________

HOME PHONE # ____________________ CELL PHONE # ____________________ WORK PHONE # ____________________ EXT # ________

E-MAIL ADDRESS ____________________

DENTAL INSURANCE INFORMATION

Primary Insurance

NAME OF INSURED

RELATIONSHIP TO PATIENT

INSURED'S BIRTHDATE SS#/SIN

EMPLOYER

DATE EMPLOYED

OCCUPATION

INSURANCE COMPANY

INSURANCE COMPANY ADDRESS

GROUP #

EMPLOYEE #/CERTIFICATE #/MEMBER ID #

$______ DEDUCTIBLE $______ AMOUNT ALREADY USED

$______ MAXIMUM ANNUAL BENEFIT

Additional Insurance

NAME OF INSURED

RELATIONSHIP TO PATIENT

INSURED'S BIRTHDATE SS#/SIN

EMPLOYER

DATE EMPLOYED

OCCUPATION

INSURANCE COMPANY

INSURANCE COMPANY ADDRESS

GROUP #

EMPLOYEE #/CERTIFICATE #/MEMBER ID #

$______ DEDUCTIBLE $______ AMOUNT ALREADY USED

$______ MAXIMUM ANNUAL BENEFIT

AUTHORIZATION *and* RELEASE

I authorize the dentist to release any information including the diagnosis and the records of any treatment or Examination rendered to me or my child during the period of such Dental care to third party payors and/or other health practitioners.

I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less that the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR

DATE

FINANCIAL ARRANGEMENTS

For your convenience, we offer the following methods of payment. Please check the option which you prefer. Payment in full at each Appointment.

- ☐ CASH ☐ PERSONAL CHECK ☐ VISA ☐ MASTERCARD
- ☐ I WISH TO DISCUSS THE DENTAL OFFICE'S POLICY.

LATE CHARGES

If I do not pay the entire new balance within 25 days of the monthly billing date, a late charge of 1.5% on the balance then unpaid and owed will be assessed each month (if allowed by law). I realize that failure to keep this account current may result in you being unable to provide additional dental services except for dental emergencies or where there is prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balance.

Thank you for filling out this form completely. The information you have provided will help us serve your dental healthcare needs more effectively and efficiently. If you have any questions at anytime, please ask - we are always happy to help.