HK DIA PI NI

Care Card: ______________________________ Today's Date: ____________________
M/D/Y

PERSONAL HISTORY

All of the information which you provide on this form will be held in the strictest confidence. Although some questions may seem unimportant at the time, they may be vital in an emergency situation. Please answer each question. Please ask the receptionist if you need assistance completing this form.

Patient's Name: ______________________________ usually called: ______________________________

Date of Birth: ______________________ Place of Birth: ______________________________ Sex: M F
M/D/Y

Home Address: ____ Postal Code: __________

Home Phone: ____________________ Name of School/Daycare: ______________________ Grade: _____

Siblings (Names & Ages): ____

Do the parents and children all live together? Yes No Preferred method of contact: home phone / cell phone / email

Parent/Guardian: ______________________________ Cell Phone: ____________________

Occupation: ____________________email or daytime phone: ______________________________

Parent/Guardian: ______________________________ Cell Phone: ____________________

Occupation: ____________________email or daytime phone: ______________________________

Alternative address: ____

Purpose of visit: ____

Any siblings seen in this office? ____

Who may we thank for this referral? ____

Who is responsible for payment of this account? ____

REGISTRATION

OFFICE POLICY

Your child's appointment time will be reserved especially for them. If you are unable to keep the appointment we require two working days notice, to avoid being charged for the time lost. We require that services are paid for at each visit as they are performed. Payment is accepted by Visa, MasterCard, Debit Card or Cash. Your insurance company will reimburse you.

DENTAL INSURANCE:

1. Employee's Name: ______________________________ Date of Birth: ______________
M/D/Y
Employer: ______________________________ Insurance Company: ______________
Group/Policy #: ____________________ Certificate/ID #: ______________________

2. Employee's Name: ______________________________ Date of Birth: ______________
M/D/Y
Employer: ______________________________ Insurance Company: ______________
Group/Policy #: ____________________ Certificate/ID #: ______________________

I authorize Dr. Pochynok to perform diagnostic procedures and treatment as may be necessary for proper dental care.
I authorize the release of information concerning my child's health care, advice and treatment provided for the purpose of evaluation and administering claims for insurance benefits.
I understand that my dental insurance carrier or payor of my dental benefits may pay less than the actual bill for services. I understand that I am financially responsible for payments in full on all accounts.
I understand that Dr. Pochynok is a certified specialist and that fees may be generally higher than general practice fees. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services.
I attest to the accuracy of the information on this page.

Parent's or Guardian's Signature: ______________________________ Today's Date: ______________
M/D/Y