Welcome!

REGISTRATION FORM

Section I: Patient Information **Date**_____

Name:_____ I Prefer to be called: _____
Address:_____City:_____State:_____Zip_____
Phone (_____)_____ Work Phone (_____) _____ Cell Phone (_____)_____
The best time to contact me is:_____ ☐ A.M. ☐ P.M. on my ☐ Home phone ☐ Work phone ☐ Cell phone
Date of Birth:_____ Social Security Number:_____
Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced
If Student, Name of School_____ City/State_____ ☐ FT ☐ PT
Spouse or Parent's Name:_____ Employer_____ Work Phone_____
Whom may we thank for referring you? _____
Person to contact in case of emergency_____ Phone_____
Email Address_____ Would you like to receive our e-newsletter? ☐ Yes ☐ No

Section II Responsible Party

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other
Name:_____ Relationship to Patient: _____
Address:_____
City:_____ State:_____ Zip:_____ Phone: (____)_____
Employer_____ Work Phone (____)_____ SSN#_____

Section III Dental Benefit Information

Name of Insured_____DOB_____Relationship to Patient _____
SSN#:_____ Name of Employer:_____ Work Phone: (____)_____
Address of Employer:_____City_____State:_____Zip _____
Insurance Company_____ Grp #_____ ID#_____
Ins Co Address:_____ Ins Co. Phone:_____

---------- DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING ----------

Name of Insured_____DOB_____Relationship to Patient _____
SSN#:_____ Name of Employer:_____ Work Phone: (____)_____
Address of Employer:_____City_____State:_____Zip _____
Insurance Company_____ Grp #_____ ID#_____
Ins Co Address:_____ Ins Co. Phone:_____

THE DENTIST
JEFFREY C. KIRIAN, DDS, LLC

Financial Policy

Thank you for choosing THE DENTIST, Dr. Jeffrey C. Kirian. Our primary mission is to deliver the best and most comprehensive care for each patient. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options. If you have any questions regarding our financial policy, please do not hesitate to speak with our Financial Coordinator. We will be sensitive to your financial circumstances within the framework of sound business practices.

Payment Options:

- Cash or Check
- VISA, Mastercard, and Discover
- Care Credit and Citi HealthCard
    - Both options allow you to pay over time, interest free

Please note:

- Payment is required prior to the completion of your treatment.
- A broken appointment fee of $35 is charged for patients who miss or cancel an appointment with less than two (2) business days notice.
- A fee of $36 will be charged to your account for returned checks.
- A billing fee of $3/month will be charged once an account is more than sixty (60) days delinquent.
- A Finance Charge will be imposed on past due balances at the Periodic Rate of 1 ½ % per month for a total Annual Percentage Rate of 18%.

Dental Insurance

-For patients with dental insurance, we are happy to work with your carrier to maximize your benefit and directly bill your primary insurance for reimbursement of your treatment (secondary and tertiary insurance are the patient's responsibility).
-We will provide you with an estimate and ask you to pay your portion at time-of-service.
-If the insurance company has not paid your claim within sixty (60) days, the total balance will automatically be transferred to your account for payment.

I understand and accept *the financial and the dental insurance policies listed above and have had any and all questions answered to my satisfaction.* ***I agree*** *to pay for all treatment in a timely fashion as described so as to avoid any additional fees.*
I hereby authorize my insurance benefits to be paid directly to THE DENTIST. *I realize that I am responsible to pay for any deductible amount(s), my co-insurance portion and for any non-covered services. I understand that I am financially responsible for any and all charges of dental treatment and incurred fees, whether or not paid by insurance and I agree to pay such charges in full. I also hereby authorize the release of pertinent medical/dental information to the insurance carrier. This order will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.*

_____ _____ _____
Patient or Guardian Signature Date Staff Initials

_____
Patient Name (Please Print)

740 N. 21ST STREET
NEWARK, OH 43055
PHONE: (740) 366-1236
FAX: (740) 368-0043
WWW.THEDENTIST.US

THE DENTIST

JEFFREY C. KIRIAN, DDS, LLC

Name _____
Last First

Date _____

Please tell us how you learned about our practice. (Select **ALL** that apply)

_____ Referral - Patient *Name:* _____

_____ Referral -Staff *Name:* _____

_____ Referral - Dentist/Dr *Name:* _____

_____ Our website

_____ Internet search (e.g. a basic search for "dentist")

_____ Insurance Company *Which insurance?* _____

_____ Pay-per-Click

_____ Local Ad

_____ Email

_____ Minizine

_____ Weathervane Program

_____ Newark Sports Program

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THE DENTIST
JEFFREY C. KIRIAN, DDS, LLC

Authorization to Communicate Health Information

Patient Name: _____ Date of Birth: _____

You may release information on my dental condition(s) to the following individuals:

1) _____

2) _____

3) _____

4) _____

This authorization will remain valid from the date of this signed document unless revoked by patient or legal guardian. The authorization applies to all episodes of care and treatment, including but not limited to results, diagnoses, and appointments. This authorization applies to all dental information stored within the office of Dr. Jeffrey C. Kirian, DDS.

_____

Patient or Legal Guardian Date

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THE DENTIST, Dr. Jeffrey C. Kirian, DDS, LLC

Acknowledgement of Receipt of Notice of Privacy Practices

* You May Refuse to Sign This Acknowledgment*

I, _____, have received a copy of this office's Notice of Privacy Practices.

Print Name_____

Signature_____

Date_____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

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