Welcome to Cheboygan Family Dentistry ..

David R. Rindfusz, D.D.S.

Name _____ Nickname _____

SS# _____ Date of birth _____

Home address _____
Street City State Zip

Mailing address _____
P.O. Box City State Zip

Home phone number _____ Cell number _____

Employer _____ Work number _____

Spouse name _____ Work number _____

Preferred method of payment: Cash _____ Check _____ Credit card _____

Emergency Contact Person _____ Phone number _____

(if minor) Who is responsible for child? _____ Relationship _____

SS# _____ Date of Birth _____ Employer _____

Insurance information

Do you have dental insurance? _____

Subscriber _____ Relationship _____

SS# _____ DOB _____

Employer _____

Insurance Co. name _____

Secondary insurance _____

Subscriber _____ Relationship _____

SS# _____ DOB _____

Employer _____

Insurance Co. name _____

I hereby authorize the doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my dental needs. Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such treatment as required to provide proper care. I agree to the use of anesthetics, sedatives and other medications as necessary. I fully understand that using anesthetic agents embody certain risk. I understand that I can ask for a complete recital of any possible complications.

*I agree to be responsible for **payment in full the day services are rendered on my behalf and my dependents**. If I have insurance I also understand that payments such as **co-pays, deductibles, and treatment not covered by my insurance must be paid in full at the time services are rendered.***

I understand that my dental insurance carrier my pay less (we can only estimate) than the actual bill for services and the difference will be my responsibility to be paid within 30 days of receipt of statement.

Signature _____ Date _____ Witness _____

Responsible Party (if minor) _____ Relationship _____

Over ⇨