Kevin Jan, DMD
Family & Cosmetic Dentistry

PATIENT INFORMATION

Patient First Name: _____ MI: ___ Last Name: _____ Preferred Name: _____
Date of Birth: _____ Preferred Phone #: _____ Email: _____
Address: _____ City: _____ State: ____ Zip: _____
How did you hear about our practice? _____ SSN: _____
Please present your insurance card and a form of identification to be photocopied for our records.

INSURANCE INFORMATION

Primary Insurance	**Secondary Insurance**
Subscriber Name: _____ Subscriber ID: _____ Date of Birth: _____ Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child Employer Name: _____ Employer Phone: _____ Insurance Company: _____ Insurance Group: _____ Insurance Phone: _____	Subscriber Name: _____ Subscriber ID: _____ Date of Birth: _____ Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child Employer Name: _____ Employer Phone: _____ Insurance Company:_____ Insurance Group: _____ Insurance Phone: _____

AUTHORIZATION

I consent to the diagnostic procedures and dental treatment performed by Kevin Jan, DMD, and to the release of information concerning my (or my child's) healthcare, advice, and treatment to another dentist, or for evaluating and administering any claims for insurance benefits. I consent to the direct payment of my insurance benefits to Kevin Jan, DMD and understand that my insurance benefits may pay less than the actual bill for services and that I am responsible for any services not paid or covered by my insurance benefits and any account balance. You will have the right to revoke this authorization at any time by giving us written notice of your revocation submitted to Kevin Jan, DMD, listed above. Please understand that revocation of this authorization will not affect any action we took in reliance on this authorization before we received your revocation.

ELECTRONIC COMMUNICATIONS: I consent to receiving HIPAA-compliant electronic communications, such as email and text messages regarding treatment, payment and health care operations. I understand there is no obligation to receive these electronic communications. Message/data rates may apply, and I may opt-out of receiving electronic communications at any time by notifying Kevin Jan, DMD.
I attest to the accuracy of the information on this page.
Signature: _____ Date: _____
(Responsible Party, if under 18)

FOR OFFICE USE ONLY
Reviewed by: _____ Date: _____

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CONSENTS & ACKNOWLEDGMENTS

INFORMED CONSENT

I understand that by coming to Kevin Jan, DMD, I acknowledge and agree to all necessary treatment dictated by the doctor, which may or may not include, but is not limited to: crowns, bridges, fillings, x-rays, extractions, root canals, cleanings, and dentures.
*Patient Initials:*_____

HIPAA

I have been given a copy or seen the authorization for use or disclosure of protected health information. Should I choose to disclose any information to a third party, I, _____, understand that by signing this Consent form, I am giving my consent to Kevin Jan, DMD to disclose and discuss my protected health information to carry out treatment, payment activities and health care operations with the following family member:

Name: _____ Relationship:_____

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to Kevin Jan, DMD. .
*Patient Initials:*_____

OFFICE USE

I authorize Kevin Jan, DMD to use patient photos for media purposes. No identifying features outside of the oral cavity and smile will be used.
*Patient Initials:*_____

INSURANCE

Kevin Jan, DMD provides insurance company billing as a courtesy to our patients. The patient portion of particular dental service(s) is estimated and due at the time of service. The amount may be subject to adjustment when the dental service(s) claim(s) are adjudicated by the insurance company. In addition, certain insurance companies have annual limitations for the amount of dental services that can be reimbursed within each plan year. If you or your family exceed these annual limitations in any plan year, you will be responsible for the full amount of dental services that exceed the particular plan's limitation. The patient is responsible for monitoring the amount of his/her remaining benefits for any annual benefit period. The patient may not rely upon any information provided by Kevin Jan, DMD staff regarding his/her remaining benefit in any such benefit period.

DELINQUENT PAYMENT

It is our policy to charge finance fees at 1.5% every 2 days for outstanding patient balances after the balance has been outstanding for 30 days. In addition, all payments returned due to non-sufficient funds will be subject to a no-show fee of $25.00

MISSED APPOINTMENTS

Unless cancelled at least 48 hours in advance, our policy is to charge for missed appointments at the rate of $75.00 per each 30 minutes of missed appointment time. Please help us service you better by keeping scheduled appointments.

Responsible Party Signature: _____ Date: _____