Patient Information

Thank you for choosing our office!
In order to serve you properly, we need the following information. Please print. All information will be confidential.

Patient Information:

First Name: ________________________________ Last Name: _________________________________Middle Initial: ______

Preferred Name: ____________________________ Date of Birth: _________________________ Male / Female

SS#/SIN: __________________________________ Driver's License#: ____

Marital Status: Married Single Divorced Separated Widowed

Address: ____ Address 2: ____

City/State/Zip: ____

Home Phone: __________________________Work Phone: _________________________Cell Phone: ____________________

Email: ______________________________________For your convenience, we are now sending email and text message reminders.
If you wish to opt out of email or text message reminders, please let our front desk know.

How did you hear about our practice? ____

Employment Status: Full Time Part Time Retired

Emergency Contact Name: _________________________

Student Status: Full Time Part Time

Emergency Contact Phone Number: __________________

Name of Employer: ____ Work Phone: ________________________________

Address of Employer: ____

Responsible Party (if other than self)

Name: ____Relationship to Patient ______________________________

Address: ____

Home Phone: ________________________ Work Phone: _______________________ Mobile Phone: ______________________

SS#/SIN: _______________________________________ Driver's License: ____

Financial Policy

Payment Options: Cash, Check, Visa, MasterCard, Discover Card, American Express, or CareCredit
We offer a 5% courtesy account adjustment to patients who pay for their treatment with cash or check in full at the time of service.
Please note:

-Rebol Family Dentistry requires payment prior to the completion of your treatment. If you choose to discontinue care before treatment is complete, you will receive a refund less the cost of care received.
-For plans requiring more than 2 appointments, alternative payment arrangements may be provided.
-For patients with dental insurance we are happy to work with your carrier to maximize your benefits and directly bill them for reimbursement for your treatment if they allow assignment of benefits.
-A fee of $50 is charged for patients who miss or cancel without a 24-hour notice.
-$35 will be charged for returned checks.

Authorization:

I authorize and give consent to Christopher R. Rebol, DDS to perform dental services agreed upon between doctor and patient (and/or parent or guardian) to be necessary or advisable including the use of local anesthesia and other medications as indicated. Payment of all treatment and services rendered are my responsibility. I understand payment is due at the same day services are rendered. I hereby authorize payment of insurance benefits, if applicable, directly to the practice. I understand that the benefits explained to me are only estimates, and I am responsible for all costs for dental treatment not covered by my insurance. Remaining balances are to be paid in full by the responsible party. I also acknowledge that I received a copy of Dr. Christopher R. Rebol, DDS, PA Notice of Privacy Practices (effective date 4.27.2015).

Patient Signature ____ Date: _______________________

If patient is less than 18 years of age or requires a guardian:

Parent / Guardian Signature ____Date: _______________________

Please turn over to review and enter Dental Insurance information.

Insurance Policy:

We do accept dental insurance and try to be familiar with the regulations and restrictions of each company and policy; however, due to the variety of plans available, the patient is ultimately responsible for understanding the details of their coverage. Dr. Rebol and his staff work for you, not an insurance company. We are happy to file your insurance for you and will work to maximize your benefits. However, we believe in the sanctity of the doctor-patient relationship and a treatment planning will always start with what is best for your long term health and not the bottom line of your insurance carrier. Should your insurance company refuse to remit payment directly to the provider, such as the new policy of BCBS of NC effective January 2014, payment in full at the time of service will be due from the patient. Please feel free to discuss any concerns you may have regarding your insurance with us.

Primary Insurance Information:

Name of Insured: ________________________________ Relationship to Insured: Self Spouse Child Other

Birth date: _______________________________ SS/SIN: ____

Name of Insured Employer: ____ Work Phone: __________________

Address of Insured Employer: ____

Insurance Company: ________________________ Group #: _______________________________

Insurance Company Address: ____

How much is your deductible? _________ How much have you used? ________ Maximum Annual Benefit? ____________

Do you have secondary insurance? If yes, please complete the following:

Name of Insured: ________________________________ Relationship to Insured: Self Spouse Child Other

Birthdate: _______________________________ SS/SIN: ____

Name of Insured Employer: ____ Work Phone: ______________________

Address of Insured Employer: ____

Insurance Company: ________________________ Group #: _______________________________

Insurance Company Address: ____

How much is your deductible? _________ How much have you used? ________ Maximum Annual Benefit? ____________