BUZA DDS PC

Welcome to your Dental Home

PATIENT INFORMATION

Patient Name: _____ Preferred Name: _____ Male: ____ Female: ____

Birthdate: _____ SSN: _____ Single: ____ Married: ____ Child: ____ Widowed: ____

Home Address: _____ City: _____ State: _____ Zip: _____

Email: _____ Home #: _____ Work #: _____ Mobile #: _____

Employer: _____ Previous/Present Dentist: _____

Other family members seen by us?: _____

Whom may we thank for referring you?: _____

Emergency Contact Name: _____ Phone: _____

If above patient is a child, please complete the following:

Parent's Information

Person Responsible for Account: _____ Parent's Marital Status: Single: ___ Married: ___ Divorced: ___

Father / Step Father / Guardian

Name: _____

Birthdate: _____ SSN: _____

Hm#: _____ Wk#: _____ Mobile#: _____

Employer: _____

Mother / Step Mother / Guardian

Name: _____

Birthdate: _____ SSN: _____

Hm#: _____ Wk#: _____ Mobile#: _____

Employer: _____

DENTAL INSURANCE

Primary Insurance Carrier: _____ Member ID#: _____ Group #: _____

Insured Name: _____ Birthdate: _____ SSN: _____

Secondary Insurance Carrier: _____ Member ID#: _____ Group #: _____

Insured Name: _____ Birthdate: _____ SSN: _____

ACKNOWLEDGEMENT

I understand that I am responsible for all fees incurred for services provided to me by Thomas Q. Buza D.D.S., PC on the day of service. I also understand that my insurance is an agreement between my insurance company and me. Insurance does not guarantee coverage or payment. I authorize Buza D.D.S., PC use and disclosure of my protected health information relating to any dental claims. I authorize payment of dental benefits to be paid directly to Thomas Q. Buza, D.D.S., PC. I certify that I have read and understand the above. I do ___ / do not ___ give Buza D.D.S., PC permission to contact me electronically via email or text messaging.

_____ _____

Patient / Responsible Party Signature Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I have received and reviewed a copy of our dental practice's privacy, security and breach notification policies and procedures. I understand that I should ask our dental practice's Privacy Official if I have any questions about these policies and procedures.

Signature:_____ Date:_____