Tappan Dental

165 Washington Street
Tappan, NY 10983
845-359-7654
info@tappandental.com

Our dental team is happy to welcome you to our practice. We are pleased that you have chosen us to care for your dental needs. We are committed to providing you with the highest quality of oral health care in the gentlest manner possible.

Please complete all new patient forms prior to your first appointment. If you have dental insurance, you will need to bring your current insurance card and a photo ID. We will be happy to electronically submit your claim forms. Payment is expected at the time of service.

If you wish to have records sent to us, complete the patient records request form and send it to your previous dentist.

A parent must be present with a child under age 18.

We recognize the value of your time. Except for an emergency situation, you can always expect us to be on time for you. We will do our best to notify you of a delay. We do have a strict policy on broken appointments. If you find it impossible to make an appointment, please call the office 24 hours in advance so that we may offer your time slot to another patient.

We look forward to meeting you.

Patient Name _____

PAYMENTS:

Payment is expected at the time of your appointment. Payment may be made with cash, credit card or check. Tappan Dental also offers interest free financing with Care credit financing.

APPOINTMENT CANCELLATIONS:

If I am unable to keep my scheduled appointment, I will call to cancel or re-schedule my appointment with 24 hour notice. If I don't call to cancel my appointment with the specified notice, and/or I have frequent last minute cancellations I may be charged the no show fees.

INSURANCE INFORMATION:

Primary Insurance: _____ID#_____
Group Number: _____
Name of Policy Holder: _____
DOB of Policy Holder: _____

Secondary Insurance: _____ID#_____
Group Number: _____
Name of Policy Holder: _____
DOB of Policy Holder: _____

PERSON RESPONSIBLE FOR PAYMENT:

Name: (First) _____ (MI) _____ (Last) _____
Date of Birth: _____ SS# _____ - _____ - _____
Relationship to the Patient: _____
Home Address: _____
Employer Name: _____
Occupation: _____
Home Phone: _____Work Phone: _____
Cell Phone: _____

FEES and PAYMENTS:

We make every effort to keep down the cost of your care. You are expected to pay your bill by completion of each visit. A pre - treatment estimate of the charge for a procedure will be given upon request. Insurance is considered a method of reimbursing the patient for fees paid to our office and is not a substitute for payment. Insurance plans vary from company to company and plan to plan. **It is your responsibility to pay any deductible, co-insurance or other balance not paid by your insurance company.**

Signature of patient:

I agree to pay for all services at the time of my visit.

Signature of patient:

I certify that the information that I have provided is correct. I authorize the release of information necessary to process insurance claims to insurance companies or their agencies for the purpose of filing and payment of dental claims.

Signature of patient:

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I have regarding this notice.

Signature of patient:

Today's Date: _____

Medical Information Release Form
(HIPAA Release Form)

Name: _____ Date of Birth: ____/_____/_____

Release of Information

[ ] I authorize the release of information including the diagnosis, records, or examination rendered to me, and claims information. This information may be released to:

[ ] Spouse_____

[ ] Child(ren) _____

[ ] Other _____

[ ] Information is not to be released to anyone.

This *Release of Information* will remain in effect until terminated by me in writing.

Messages

Please call [ ]my home [ ]my work [ ]my cell number _____
If unable to reach me:

[ ] you may text me

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] _____

[ ] The best way to reach me is via email _____

[ ] I prefer to not be notified by text or email

Signed: _____ Date: ____/____/_____
Witness: _____ Date: ____/____/_____

PATIENT RECORDS REQUEST FORM

Name of Patient Requesting Records_____

Date of Birth_____ Phone_____

Address_____ City/State/Zip_____

Name and address of practice sending records _____

_____

Please send:

The full health record (and x-rays) maintained by provider/practice _____

The health record for the following time frame: _____through_____

A specific section of health records as described below:

_____

_____

_____

Signature of Patient_____

Name of Patient (please print) _____

Relationship to Patient (if other than patient)_____

Date_____

Please send to:

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