Today's Date : _____

WELCOME

Name: _____
First Middle Last

I prefer to be called : _____

Birth Date ___ /___ / _____ SSN# _____ - ___ - _____

Sex: Male Female

Home Address: _____

Apt#___ City/Zip: _____

e-Mail: _____

Home Ph# : _____ Work Ph# : _____

Cell Ph# : _____

Please note: By providing us with you cell phone number we may use it to call, leave messages, or text you reminders.
To **opt out** from the use of your cell phone number please initial this box. ☐

⇒ Employment History:

Occupation: _____

Employer : _____

Work Address: _____

_____

Spouse's Name : _____

Spouse's Birthday : _____ /_____ / _____

Spouse's Occupation: _____

How did you hear about us? _____

How long has it been since your last dental visit? _____

Previous Dentist Name? _____

HIPAA Waiver

Dr. Syribeys complies with all HIPAA Federal Statutes. He will never sell or give patient personal information to anyone who is not working on the patient's case without the patient's permission. His Notice of Privacy Practices is posted in his office in a clear and prominent location and copies are available upon request.

I understand my rights under HIPAA and that Dr. Syribeys must make a good-faith attempt to obtain written acknowledgement of my receipt of the Notice. By signing below I am stating that I do not need a copy of the Notice of Privacy Practices and understand that I can request one at any time.

X _____ Date _____

Insurance Information

⇒ **Do you have a Dental insurance policy?**

If **YES** please answer the following...

Insurance Name _____

Plan Num# _____ Group Num# _____

Phone# _____

Address: _____

_____

⇒ **Are you the Subscriber?** **Yes** **No**

Name of Subscriber : _____

Insured's Birthday ___ /___ / _____ SSN ____ - ___ - _____

Employer: _____

Work Ph# _____

Address : _____

_____

Relationship to the Subscriber:

Spouse Child Other: _____

I, the undersigned certify that I (or my dependent) have insurance coverage with the carrier listed above, and assign directly to Dr. Syribeys all insurance benefits, if any, otherwise payable to me for services rendered. I understand that my choice of insurance coverage is a matter that does not involve Dr. Syribeys in anyway.
I am financially responsible for charges whether or not paid by insurance.
I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

X _____ Date _____

IN CASE OF AN EMERGENCY (Specify non household contact)

Name : _____

Home Ph# : _____ Cell Ph# : _____

I understand that Dr. Syribeys utilizes electronic devices to aid in the treatment and security of his patients. This office utilizes electronic devices to aid in confirming the sterility of instruments, disinfection of operatories, and other quality control issues. All dental and financial interactions with the office of Dr. Syribeys are subject to complete documentation as a matter of record.

X _____ Date _____