Prosthodontic solutions

First name: _____

Last name: _____

Please circle preference: Mr Mrs Ms Dr Atty ___

Preferred name: _____
(How do you prefer we address you?)

ADDRESS and PHONE

Street _____

City _____

State _____ Zip _____

□ Home phone: ( ) - _____ - _____

□ Work phone: ( ) - _____ - _____

□ Mobile phone: ( ) - _____ - _____

Do you prefer text messages? Yes / No

* Please check which phone you prefer us to call

Email: _____

PERSONAL

Date of Birth: ___ / ___ / _____ Sex: □ M □ F

Occupation: _____ Retired? □ Y □ N

Rate the following from most to least important:
(5 = most important, 1 = least important)

____ Ability to chew/bite
____ Appearance of Smile
____ Comfort of teeth/mouth
____ Desire to keep your natural teeth
____ Long-term results

Caregiver/Parent/Guardian contact

Whom should we ask for consent? _____

Name: _____

Relation: _____

Emergency contact: ( ) - _____ - _____
(If different from above)

□ Patient is dependent youth or minor
□ Patient is dependent elderly
□ Other: _____

PATIENT INFORMATION

Date: ___ / ___ / _____

Whom may we thank for referring you?

Name: _____

Address/City: _____

PAYMENT POLICY

Payments for routine services such as examinations, x-rays, basic fillings, and emergency visits are due at the time services are provided. We accept cash, major credit/debit cards, checks, or money orders.

Once payment has been made for services, we will assist you in maximizing your insurance benefits. Insurance claims can be filed by the office or you may choose to file your own claim. You will then be reimbursed directly by the insurance company.

A written estimate will be provided for all comprehensive prosthodontic/restorative plans. If you have insurance coverage, a predetermination can be sent upon request so you are aware of the benefit amount. In general and for most complex situations, dental insurance benefits are only a small portion of the prosthodontic care required. A down payment is required for all complex or extended treatment, regardless of estimated payment by your insurance company. Balances not covered by insurance are due at the time services are provided.

We understand that the high quality treatment we provide is expensive and work hard to keep it as reasonable as possible.

Michael P. Waliszewski DDS, MsD

I have read and understand this policy:

_____ _____
Signature (Patient or Parent/Guardian) Date

Prosthodontic Solutions

Acknowledgement of Receipt of HIPAA Notice of Privacy Practices

I, _____, hereby acknowledge that I have received and reviewed a copy of Prosthodontic Solutions HIPPA Notice of Privacy Practices.

I understand that Prosthodontic Solution's HIPAA Notice of Privacy Practices may change periodically and that I am entitled to receive a copy of Prosthodontic Solution's revised HIPA Notice of Privacy Practices upon request. If I have questions about this I may contact Dr. Michael Waliszewski or his staff at this office. I may also contact the Secretary of the U.S. Department of Health and Human services (contact available on .gov website) should I have concerns.

I understand that it is my right to refuse to sign this acknowledgement should I so choose, and that Prosthodontic Solutions will not refuse treatment to me if I refuse.

_____ _____

Signature Date

_____ _____

Print name Relationship to patient (if guardian/power of attorney)

Photographic Release Acknowledgement

Dr. Michael P. Waliszewski or his staff may request to take photographs of your situation. These photographs are typically taken for diagnostic reasons and therefore are important in assuring an optimal outcome. Occasionally, photographs of unique situations or exceptional results are requested. These images are your property and can be requested at any time.

If you authorize Dr. Michael P. Waliszewski to use these images for any of the following alternative uses please sign check the boxes you will allow and sign below.

- □ **Non-identifiable intra-oral images** (of teeth or tissue only)
- □ **Full face photographs showing before and after results**

- □ **I allow these images to be used for educational purposes**
  (lectures to students and dentists, professional publications, textbooks)
- □ **I allow these images to be used by Prosthodontic Solutions LLC**
  (examples to show other patients, website, in-office printed images)
- □ **I will ONLY allow use of images to help treatment my condition**

Authorized by: _____ _____

Signature Date