Central Virginia Dental Care, PLC

David Circeo, DDS
6113 Lakeside Avenue, Richmond, VA 23228
804-262-9824

PATIENT INFORMATION

Name_____ Preferred Name_____
Address_____
City, State Zip _____
Phone Home_____ Work_____
Cell_____
Male/Female Marital status_____ Date of Birth_____
Social Security #_____
E-mail_____

RESPONSIBLE PARTY INFORMATION

Name_____ Relationship to Patient_____
Address_____
City State, Zip_____
Phone Home_____ Work_____
Cell_____
Male/Female Marital status_____ Date of Birth_____
Social Security #_____

DENTAL INSURANCE INFORMATION

Name of Subscriber_____Date of Birth_____
Subscriber ID#_____
Insurance Co. Name_____Insurance Co Phone # _____
Employer_____ Group #_____

SECONDARY DENTAL INSURANCE INFORMATION

Name of Subscriber_____
Subscriber ID#_____
Insurance Co. Name_____ Insurance Co Ph #_____
Employer_____ Group #_____

Whom may we thank for referring you? _____

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INSURANCE AUTHORIZATION, ASSIGNMENT AND RELEASE

I certify all information provided is correct to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance to release the assignment of benefits directly to the dentist otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

We are glad to assist you in securing payment of claims, but ask that you pay your estimated portion when services are rendered. In fairness to the dentist, patients must understand insurance is a contract between the patient and the insurance company.

Payment of professional fees is due in full, unless arrangements are approved prior to treatment.

We accept Cash, Checks, Money Orders, Mastercard, Visa, Discover, American Express and Care Credit.

As a service to our patients who are covered by insurance, the office can assist in filing the insurance claim. Any co-payments, however, are due when services are rendered.

The fee for a returned check is $45.00.

We reserve the right to charge a fee per appointment time if appointment is broken or cancelled with less than a 24-hour notice.

I agree to be responsible for payment of all services rendered on behalf of my dependents and myself. I agree to pay all costs of collections including collections/attorney's fees if I default.

Signature_____ Date_____

Patient (or) Parent/Responsible Party (if a minor)