DUNKIRK DENTAL ASSOCIATES

Yuey Moy, D.D.S. Robert Hoerauf, D.D.S. Mark Frazer, D.D.S.

The benefits of a happy smile are immeasurable. Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for your dental needs.

Patient Information

Date: _____

First Name: _____ Last: _____ MI: _____ I prefer to be called: _____

(Circle one) Mr Mrs Ms Miss Dr.

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

Home #: _____ Work #:_____ Ext: _____ Cell #: _____

Date of Birth: _____ Sex (M) _____ (F) _____ Age: _____ S.S #: _____

Previous Dental Office: _____ Date of Last Cleaning Appointment: _____

Date of Previous X-Rays: _____ Dental Concern or Issue: _____

Employer: _____ Address: _____

E-mail: _____ May we send appointment reminders, statements, etc, via email? Yes/No

Spouse's Name: _____ Phone: _____ Address: _____

****Person Responsible for Account**: _____ Relationship: _____ S.S. #: _____

Address: _____ Contact #: _____ DOB: _____

Emergency Contact Name: _____ Hm Phone #: _____ Cell #: _____

****How or by whom did you hear about our practice? _____** Relationship: _____

Other family members seen in our office: _____

Dental Insurance

Subscriber's Name: _____ DOB: _____ Hm Phone #: _____

Cell #: _____ Subscribers Address: _____ Zip: _____

****Subscriber's Employer Name: _____ Union #: _____**

Subscriber's Employer Address: _____ Zip: _____

Subscriber's S.S. # or ID#: _____ Employers Phone #: _____

Insurance Co. Name: _____ Policy or Group #: _____

Insurance Co. Address: _____

Zip: _____ Insurance Co. Phone #: _____ Effective Date: _____

I understand that the information that I have given is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform the office of any changes in my or my chills medical status. I authorize the dental staff to perform any necessary dental service that may be needed during diagnosis and treatment with my informed consent.

I understand that I am responsible for all changes incurred regardless of my insurance status. Changes not paid within ninety (90) days by my insurance will be the patient's responsibility. I further agree, I the event of default due to nonpayment, to be responsible for collection fees, court cost and/or legal fees and there will be a fee for all returned checks. I hereby direct benefits payable to attending dentist.

Our office is HIPPA compliant and committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and ADA. Please, review the HIPPA Privacy Statement located in the waiting room.

If you have any questions at anytime, please ask us, we are happy to help.

Signature: _____ **Date**: _____