Welcome to GPS Dental

Thank you for giving Dr. Gary P. Skrobanek and staff the opportunity to provide your dental healthcare needs. Please complete this form in ink.

Your Child

Child's Name _____
Nickname_____ Sex_____
Birth date _____ Age_____
SS # _____
School_____ Grade_____
Child's Home Address_____
City_____ State_____ Zip_____
Phone H/C_____

Responsible Party

Name_____
Relationship_____
Address _____
City_____ ST_____ Zip_____
Email _____
SS#_____ DL#_____
Birth date_____
Phone C/W_____

Who is responsible for making appointments and bringing child?

Name_____ Relationship_____

List best numbers to call in order of preference and indicate cell, work, or home.

1)_____C/W/H 2)_____C/W/H 3)_____C/W/H

Mother ☐ stepmother ☐ guardian

Name _____
Phone_____
Email_____
Employer_____
SS#_____
Birth date_____
Marital Status: Single/Married/Divorced/Separated

Father ☐ Stepfather ☐ Guardian

Name_____
Phone_____
Email_____
Employer_____
SS#_____
Birth date_____
Marital Status: Single/Married/Divorced/Separated

Primary Insurance

Insured's Name _____
Relationship _____
Birth date _____SS# _____
Employer _____
Insurance Co. _____
Ins. Co. Phone #_____
Group/Policy # _____ Member # _____

Additional Insurance

Insured's Name_____
Relationship _____
Birth date _____ SS# _____
Employer _____
Insurance Co. _____
Ins. Co. Phone # _____
Group #_____ Member #_____

Please provide a copy of your insurance card, and driver's license for our records.

Financial Arrangements Payment for services rendered is due in full at the time services are completed. For your convenience, we offer to bill your insurance for their estimated portion and accept cash, personal check or credit card for the remainder. Please be fully aware that you are responsible for any amount that is not paid or covered by your insurance, regardless of the circumstances for their non-payment.

Release of Information

I authorize the release of any dental information to process this claim.

X_____ Date_____

Assignment of Benefits

I authorize payment directly to the providing dentist for insurance benefits otherwise payable to me.

X _____ Date_____

Please note: Some procedures performed may not be covered by certain insurance plans, especially plans where benefits are determined by company/employer fee schedules. Cost of treatment that is denied by insurance becomes the patient's responsibility. Your insurance does not furnish us with a specific fee schedule for your individual policy or group plan. We are only given a "general fee schedule" and can only estimate what your insurance will pay. To avoid unanticipated costs, it is your responsibility to be informed as to what your insurance plan will cover prior to treatment. Please remember that we file your treatment with your insurance as a courtesy to you. This is not our responsibility and any disputes or dissatisfaction that occurs with your insurance company are your responsibility. All balances that remain after your insurance has paid is your responsibility regardless of the reason for non-payment by your insurance company. In order to avoid unanticipated costs, it is your responsibility to be informed as to what your insurance plan will cover prior to your treatment.