# 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.

## Patient Information (*confidential*)

Name _____ Birth date _____Sex_____
Address _____ SS # _____DL #_____
City_____ ST_____ Zip_____ Marital Status: Single/Married/Divorced/Separated
Email _____ Spouse Name_____

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

## Responsible Party *(Person Responsible for payment of this account)*

Name _____ Relationship to Patient_____
Address _____ Birth date _____ Sex_____
City _____ST_____ Zip_____ SS # _____ DL #_____
Employer _____ Work Phone _____
Work Address _____ City _____TX_____ZIP_____

Person to contact in case of emergency: _____

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

## 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.