Treasured Smiles
DENTISTRY, LLC
Specializing in Children, Providing for the Family

**Michael Kasper, D.D.S.**
**Niki Kasper, D.D.S.**
**General and Cosmetic Dentistry for Adults**

# Welcome!

## Tell us about yourself

Name:_____ male/female Birth date:____/___/____

## Responsible Party Information

**Name of Patient**_____

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

Home Phone (____) _____ Cell Phone (____) _____ Work Phone (____)_____

Date of Birth: ____-____-____ SSN: _____-____-_____ Drivers License #: _____

E-mail _____

Employer: _____ Occupation _____

Employer Address: _____

**Name of Spouse**: _____

Address: ☐same_____ City: _____ State: ____ Zip:_____

Home Phone (____) _____ Cell Phone (____) _____ Work Phone (____) _____

Date of Birth: ____-____-____ SSN: _____-____-_____ Drivers License #: _____

E-mail _____

Employer: _____ Occupation _____

Employer Address: _____

**Whom may we thank for referring you to our office?**_____

**We are excited to know if you were referred to us by any of our other sources:**

- □ Family Time Magazine
- □ Frankfort HomePages
- □ Frankfort/ Tinley Yellow Pages
- □ Greater Will County Yellow Pages
- □ Internet/ Website
- □ Internet Yellow Pages
- □ Mokena HomePages
- □ New Lenox HomePages
- □ New Lenox Patriot
- □ Orland Park Yellow Pages
- □ Parent Magazine
- □ Southtown Newspaper
- □ Sun Newspaper
- □ Other_____

****Please Complete the Reverse Side of This Form****

# Insurance Information

*As a courtesy, our office can file insurance claims on your behalf.*

□ I **DO NOT** have dental insurance. I will be paying by the following methods at the time of service…

□Cash □Personal Check □Credit Card
□CareCredit (payment plan option)

□ I **HAVE** Dental Insurance. I will be paying for my portion of services rendered with the above method at the time of treatment, and my insurance company will be billed for their portion by Treasured Smiles (Niki Kasper, D.D.S. or Michael Kasper, D.D.S.) My insurance information is provided below.

***The person with the earliest birth date in the calendar year is the primary insured***

Primary Insured's Name: _____ Date of Birth: ____/____/_____

Social Security Number: _____-_____-_____

Employers Name: _____ Work Phone: (_____) _____

Work Address: _____ City: _____ State: ___ Zip: _____

Insurance Company: _____ Insurance Co. Phone: (_____) _____

Insurance Co. Address: _____ City: _____ State: ____ Zip: _____

Group or Plan Number: _____ Policy Number: _____

Union Name: _____ Local #: _____

□ I have a Second Insurance as well…
Secondary Insured's Name: _____ Date of Birth: ____/____/_____
Social Security Number: _____-____-_____
Employers Name: _____ Work Phone: (_____) _____
Work Address: _____ City: _____ State: ___ Zip: _____
Insurance Company: _____ Insurance Co. Phone: (_____) _____
Insurance Co. Address: _____ City: _____ State: ___ Zip: _____
Group or Plan Number: _____ Policy Number: _____
Union Name: _____ Local #: _____

## Authorization and Release

I, the undersigned (legally responsible party), authorize all dental treatment to be rendered by the dentist and staff of Treasured Smiles. I will keep the office informed of changes in my health, address or financial information. I authorize Treasured Smiles to release any information including the diagnosis and records of any treatment or examination to third party payors. I authorize Treasured Smiles to submit insurance claims on my behalf, and assign directly to Treasured Smiles all insurance benefits, if any, otherwise payable to me for services rendered. I authorize the use of signature on all my insurance submissions, whether manual or electronic. I assume full financial responsibility for all fees of services rendered, regardless of the level of reimbursement by the insurance plan. I understand that the insurance plan is a contract between the employer of the person who is insured and the insurance company, and not a contract with the dental office. I understand that treatment plans may change during treatment, and will be informed of the changes, but am still responsible for payment. I certify that I have accurately answered all of the questions asked of me to the best of my knowledge.

**x**_____
Signature Date