**Treasured Smiles Adult and Cosmetic Dentistry**
**Michael Kasper, D.D.S.**
**Niki Kasper, D.D.S.**

# Welcome!

## Tell us about yourself

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

## Patient 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: _____________________________________________________________________________

## Responsible Party Information

**(if different than Patients' Information)**

**Name of Responsible Party**: ____________________________________________________________________

Address: ________________________________ 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:**

- □ Internet/ Website
- □ Frankfort HomePages
- □ Orland Park Yellow Pages
- □ Family Time Magazine
- □ Mokena HomePages
- □ New Lenox HomePages
- □ Frankfort/ Tinley Yellow Pages
- □ Greater Will County Yellow Pages
- □ Internet Yellow Pages
- □ 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 Adult and Cosmetic Dentistry (Niki Kasper, D.D.S. or Michael Kasper, D.D.S.). My insurance information is provided below.

**If the patient also has coverage under his/her spouse's dental insurance policy, the patient's own dental insurance policy will always be filed as "**Primary**" first, and the spouse's dental insurance will be filed as "**Secondary**".

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 Adult and Cosmetic Dentistry. I will keep the office informed of changes in my health, address or financial information. I authorize Treasured Smiles Adult and Cosmetic Dentistry to release any information including the diagnosis and records of any treatment or examination to third party payors. I authorize Treasured Smiles Adult and Cosmetic Dentistry to submit insurance claims on my behalf, and assign directly to Treasured Smiles Adult and Cosmetic Dentistry 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