Welcome!

When it comes to dentists, we know that you have many options. Our goal is to get to know you as a whole person, and plan to do so through open and honest communication.

Please fill out this form completely so that we can provide you with the best possible service.

Today's Date

About You

☐ MR. ☐ MRS. ☐ MISS ☐ MS. ☐ DR.

Full Name _____ (LAST / FIRST / M.I.)

Preferred Name _____

Gender _____ Birthdate ____/____/_____ Age ____

SS# ___-___-_____ Drivers Lic. # _____ State ____

Address _____

City _____ State _____ Zip _____

Email _____

Telephone: (CHECK PREFERRED)
☐ Home _____
☐ Work _____
☐ Mobile _____

Your Employer _____

Employer Telephone _____

Employer Address _____

☐ SINGLE ☐ MARRIED ☐ PARTNERED ☐ DIVORCED ☐ SEPARATED ☐ WIDOWED

Spouse/Partner Name _____

How did you hear about us? Name of referral: _____

May we thank this person? Yes ☐ No ☐

Family members seeing us: _____

Person Responsible for Account

☐ Same as patient (skip this section)

Name _____ Gender ____

Relationship _____ Birthdate ____/____/_____

Address _____

City _____ State _____ Zip _____

Telephone - Home _____

Work _____

Mobile _____

SS# ___-___-_____ Drivers Lic. # _____ State ____

A.R. WYNNYKIW, DDS, PLLC

Progressive General & Cosmetic Dentistry

Medical Contacts

	Yes	No
Do you have a personal physician?	☐	☐

Physician's Name _____

Telephone _____

Last Date of Visit _____

Emergency Contact(s):

Please list individual(s) we may contact in an emergency.

Name _____

Relationship _____

Telephone - Home _____

Work _____

Name _____

Relationship _____

Telephone - Home _____

Work _____

Dental Benefits

☐ I do not have dental benefits.

Primary Insurance:

Insurance Company _____

Address _____

City _____ State _____ Zip _____

Telephone _____

Insured's Name _____

Birthdate ____/____/_____ Relation _____

Telephone _____

Employer _____

Policy ID or SS# _____ Group # _____

Secondary Insurance:

Insurance Company _____

Address _____

City _____ State _____ Zip _____

Telephone _____

Insured's Name _____

Birthdate ____/____/_____ Relation _____

Telephone _____

Employer _____

Policy ID or SS# _____ Group # _____

A.R. WYNNYKIW, DDS, PLLC
Progressive General & Cosmetic Dentistry

Financial Agreement

Our first priority is to provide you with advanced, highest quality dental care. Our practice depends on reimbursement from our patients for the costs incurred in their care to remain viable. We will help you to know your payment obligations in advance of treatment so that payment can be provided by you in full at the time services are rendered.

Person responsible for account: Please read the following and sign and date at the bottom of this form.

1. Payment is made in full on the date services are provided. Payment can be made via Cash, Check, Visa, MasterCard, American Express, Discover, CareCredit, Money Order, and Certified Check. Returned checks are subject to a $25.00 surcharge to your account.
2. We offer CareCredit to you as a financing option so that you are able to make convenient, budget-friendly monthly payments, if needed. CareCredit offers 6 and 12 month no interest plans and longer-term payment plan options with interest to its clients. We will be glad to help you apply and answer any questions you may have.
3. A 5% courtesy can be deducted from your fees for services over $300.00 should you pay by cash, check, money order, or certified check.
4. Dental Benefits: We will gladly file a claim to your dental benefits carrier as a courtesy to you. Your claims will be filed in order that the insurance carrier will reimburse you directly. All payment for services, regardless of coverage, is due in full at the time treatment is rendered. If you have not received reimbursement from your insurance carrier within 45 days of the date of service, please advise us and we will do our best to research the claim status as a courtesy to you. Note: No services are provided in this office under any assumption that an insurance carrier will provide payment. Your signature on this financial agreement serves as your agreement to allow us to file an insurance claim on your behalf.

I have read and understand the financial policy of A.R. Wynnykiw, DDS, PLLC. I understand that as the guarantor of this account, I am responsible for all fees applied to the account for treatment provided and products purchased and that these fees are expected to be paid in full at the time services are rendered. In addition, I am aware that balances over 60 days past due are subject to an 18% APR (1.5% per month) finance charge. **A 24-hour notice is required for any changes in scheduled appointments. Appointments missed or changed with less than 24-hour notice are subject to a $50.00 fee.**

Date _____ Name of Responsible Party _____ Signature _____

Authorization to Use Photographs, Name, or Likeness

Photographs are routinely taken as part of our clinical protocol. Without this optional, signed authorization, we will not use them for other purposes.

I authorize A.R. Wynnykiw, DDS, PLLC to use clinical and portrait photographs of my face, jaws, gums, and teeth. I do not expect compensation, financial or otherwise, for the use of these photographs. I understand that you will not use my last name and will not divulge any personal information unless express written consent is obtained. I give you, for marketing and educational purposes, permission to use: ☐ **my first name** ☐ **a pseudonym**

Educational Purposes.
I understand that the photographs taken will be used as a record of my care, and may be used for educational purposes including but not limited to lectures, demonstrations, and publications (dental magazines, journals, professional websites, etc.).

Marketing & Advertising.
I understand that the photographs taken may be used in marketing materials, including, but not limited to web site publication, print marketing, and social media. I understand that when I reveal my identity and/or relationship with this practice in any public/electronic forum, including, but not limited to **Facebook** or electronic review websites, it will be considered my voluntary release of that information.

I hereby release, discharge and agree to hold harmless all persons acting on behalf of A.R. Wynnykiw, DDS, PLLC from any liability by virtue of any blurring, distortion, alteration, optical illusion, or use in composite form, whether intentional or otherwise, that may occur or be produced in the taking of said picture or in any subsequent processing thereof, as well as any publication thereof, including without limitation any claims for libel or invasion of privacy.

I hereby warrant that I am of full age and have the right to contract in my own name. I have read the above authorization, release, and agreement, prior to its execution, and I am fully familiar with the contents thereof. This release shall be binding upon me and my heirs, legal representatives, and assigns.

Date _____ Name _____ Signature _____

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