Domenic D'Amico, DMD

359 Main Street
Watertown, MA 02472
(617)926-1801
FAX: (617)923-9618

"Creating healthy, beautiful smiles....for a lifetime."

Welcome to Dr. D'Amico's office. We sincerely appreciate you choosing our office for your health care needs. Please be assured that we will work hard to continually earn the trust that you have placed in us. In order for us to serve you better, please take several minutes to complete this information form as thoroughly as possible.

Please tell us about yourself

Today's Date: _____

Patient's Name: _____ Home Phone: _____

Address: _____ Cell Phone: _____

City: _____ State:_____ Zip: _____ Date of Birth: _____ Sex: M F

e-Mail Address: _____ Social Security #: _____

Who may we thank for referring you to us for care?_____ Do you have Dental Insurance? Yes No

Are you: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Seperated

If the Patient is a minor, please tell us about you, the parent or guardian:

Your Name: _____ Relationship to Patient: _____

Your Address: _____ Your Home Phone #: _____

City: _____ State:_____ Zip: _____ Your Social Security #: _____

Employer Information

Employer Name: _____ Business Phone: _____

Employer Address:_____ Your position: _____

City: _____ State:_____ Zip: _____

Insurance Information

Insurance claims for your carrier are filed as a courtesy at no charge to you

Name of Insurance Co:_____ Insurance Co. Address: _____

Name of Insured Person: _____ Group No./ Effective Date: _____

Subscriber # of Insured: _____ Insured Date of Birth: _____

What is your annual deductible? _____ Max annual benefit? _____

Additional Insurance Information

Insurance claims for your carrier are filed as a courtesy at no charge to you

Name of Insurance Co:_____ Insurance Co. Address: _____

Name of Insured Person: _____ Group No./ Effective Date: _____

Subscriber # of Insured: _____ Insured Date of Birth: _____

What is your annual deductible? _____ Max annual benefit? _____

AUTHORIZATION for TREATMENT: This is to certify that I, the undersigned Patient or Guardian, consent to all medical procedures agreed to between myself and D'amico DMD, PC , including the use of local, inhalational, sedative or general anesthesia as indicated, and I will assume complete responsibility for all fees associated with those procedures. I agree that all fees are due and payable, in full, at the time services are rendered.

_____ _____

Patient's (Guardian's) Signature Date

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Patient Financial Policy

Welcome to the office of Dr. Domenic D'Amico. We want to make your visit productive and enjoyable. We are happy to answer any and all questions regarding insurance plans and payment policies.

Our Policy requires payment at the time of service for your visit.

If you are a member of a dental Insurance Plan and have chosen us as a provider of your care, it is your responsibility to:

- Provide us with information relative to your claim, including insurance card, number, employer, birth date, address and Social Security number. This information is requested on the Patient Registration form, which we ask that you complete during your initial or subsequent visit.
- Pay your deductible or co-pay at the time of service.
- Pay for services not covered by your insurance carrier.

Insurance claims for your carriers are filed as a courtesy at no charge to you.

- To assist you with your payment, our office accepts Visa, Mastercard, Discover and American Express.
- Personal checks are accepted with proper identification.

When your bill is unpaid, a collection agency may be chosen to manage delinquent accounts. If your account is placed with a collection agency, you will be responsible for all costs of collection.

Cancellation Policy

- We require a 24 hour cancellation notice for a scheduled appointment.
- Patients who fail to show for their scheduled appointment without giving due noticed will be charged a $15.00 fee. This is not payable by your insurance.

I have read and fully understand my financial responsibilities under this policy.

PATIENT/GUARANTOR SIGNATURE

DATE