Preeti Gupta, DDS or Eshansh Arora, DDS
15-01 Broadway, Suite 18, Fairlawn, NJ 07410
Tel. 201-475-1600 Fax. 201-796-6444

Certification

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his / her staff, responsible for any errors or omissions that I have made in the completion of the medical history form.

Authorization (& General Consent)

I authorize my dentist and his / her designated staff, to perform an oral and maxillofacial examination, for the purpose of diagnosis and treatment planning.
Furthermore, I authorize the taking of all x-rays required as a necessary part of this examination. In addition, if medically necessary, I authorize the release of any information acquired in the course of my examination and treatment. I authorize all required general dental treatment to be performed (including but not limited to crowns, extractions, fillings, and other required treatment).

_____

(Patient or Guardian Signature)

Agreement To Sign Over Benefit Payment/ Fees and Payments

REGARDING PATIENT (PRINT NAME) : _____

In consideration of dental treatment to be rendered to me or my dependent, I agree to sign over every dental and medical benefit payment issued to me for dental services performed by this office within ten business days after receipt from a Dental Service Corporation, Health Service Corporation, Dental Plan Organization, any insurance, provided, however if the amount owed to this office is less than the amount of the dental benefit payment, then only the balance owed shall be paid.

I authorize release of information necessary to process my claim, and payment to the doctor of benefits otherwise assigned to me.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute of payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company. You will be responsible for all collection costs, attorney fees, and court costs. The signature is my authorization to agree to reimburse doctor for all collection, attorney, and court costs if my account is delinquent.

_____ _____

(Patient or Guardian Signature) Date

APPOINTMENT NOTICES

We are here to help all of our patients gain and maintain their dental health. Unfortunately, we have only a limited amount of chair time available to do so. Our time is not only valuable to us, but also to your fellow patient.

Please, regard our office policies:

1.) If it is necessary to cancel an appoint, please do so within 24 hours prior to your appointment, to avoid a cancellation fee.

2.) If a patient does not show for their appointment without notice to our Staff, we reserve the right to charge a fee for that broken appointment.

Our fee: $75.00

Patient/Guardian Signature:_____