ANN MINEO KANIA Incorporation DDS, DMSc
Diplomate · American Board of Periodontology

Periodontics · Laser · Dental Implants

Information Reference

Patient Name: ______________________________

Do you authorize consent to discuss information with a representative (spouse, family member, friend, trustee)? ______________________________

Name(s) Representative: ______________________________

Relationship: ______________________ Phone: ______________________

Health Information: Yes / No Financial Information: Yes /No

Message Preference for Appointment

Where would you like message left?

Home: ☐ Simple ☐ Detailed Cell: ☐ Simple ☐Detailed

Work: ☐ Simple ☐ Detailed Email: ☐ Simple ☐Detailed

Records Authorization

I authorize the doctor and staff to take x-rays images, study models, impressions, photographs, film, video or other records for diagnostic and educational presentations. I authorize the doctor and staff to release and share animation and records regarding my care with doctors and other healthcare providers, insurance companies or financial agents.

Payment and Insurance

I understand that the doctor's relationship as a dental care provider is with me, not any insurance company, credit service or other financial agents that I may utilize. While Dr. Kania and staff will file insurance claims as a courtesy to me, all changes and fee are ultimately my responsibility from the date that any evaluation or services are rendered. I am encouraged to understand my dental benefits and responsible to inform this office of any changes to my benefits or coverage.

Payment is required at the time of service, unless other arrangements have been made. There is a $50.00 fee for returned checks. A fee may be charged if less than 48 hours is provided to change an appointment.

Signature of Patient or Representative: ______________________________

Relationship: ______________________ Date: ______________________