Welcomes You

Michael Taras DMD, LLC.
2900 Hamilton Blvd
Allentown, PA 18103
(610) 432-1320

Patient Information

Name_____ SS#_____-_____-_____ DOB_____/_____/_____

Address_____ City_____ State_____ Zip_____

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Minor

Student Status? ☐ F/T ☐ P/T ☐ No Primary Insurance _____

School _____ Secondary Insurance _____

How did you hear about the office? _____

Contact Information

Home: (_____) _____-_____ Cell: (_____) _____-_____

Email: _____ Work: : (_____) _____-_____ Ext: _____

Emergency Contact: _____ Phone: (_____) _____-_____

Additional Information

CONSENT – I give Dr. Taras and his staff my consent to provide any dental services and treatments they deem necessary for my dependents and myself.

CHANGES – I will inform Dr. Taras and his staff, in writing, if my dependents or I have any changes in our health history, medications, or insurance coverage, prior to being treated.

INSURANCE - I certify that I, and/or my dependent(s), have dental insurance coverage as above and assign directly to Michael Taras, DMD, LLC and/or Dr. Michael Taras all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all treatment rendered and charges incurred (whether or not my dental insurance pays as expected). I authorize my signature to be kept on file and to be used for all insurance submissions.
The above named corporation and dentist may use & disclose my personal and health care information to insurance company(ies) and their agents for the purpose of obtaining payment for services rendered and determining insurance benefits for me and my dependents.

APPOINTMENTS - My signature below confirms that I understand that Dr. Taras incurs costs to see me at this office. Therefore, if I miss an appointment, cancel with less then 24 hours notice or arrive 10 minutes after my scheduled appointment time, I may be discharged from the practice.

CHECKS – I agree to pay Dr. Taras $35 for any of my checks returned for insufficient funds (i.e.-bounced checks).

COLLECTIONS – I agree to reimburse Dr. Taras 100% of any and all court, attorney, collection, detective, & arbitration costs, he incurs, related to outstanding balances owed by my dependents or me.

Signature of Patient (or Legal Guardian if a minor)_____ Date____/____/____

Print name of Patient (or Legal Guardian if a minor)_____