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

Periodontics • Laser • Dental Implants

Welcome to our office.
Thank you for selecting our office for your periodontal and dental implant care.

Patient Information

Name (Mr., Mrs., Ms., Dr.)
Last _____ First _____ Middle _____

If patient is a minor, name of mother and farther: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ SS# _____ Other ID: _____

E-mail: _____ Home Phone: _____ Cell Phone: _____

Occupation: _____ Business Phone: _____

Spouse Information

Spouse Name/Other Responsible Person Name
Last _____ First _____ Middle _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ SS# _____ Other ID: _____

E-mail: _____ Home Phone: _____ Cell Phone: _____

Occupation: _____ Business Phone: _____

In Case of Emergency

Emergency Contact Name
Last _____ First _____ Middle _____

Relationship: _____ Phone Number: _____

Whom may we thank for referring you? _____

Insurance Information

Primary: _____ Policy / Group # _____

Subscriber Name: _____ Date of Birth: _____

Secondary: _____ Policy / Group # _____

Subscriber Name: _____ Date of Birth: _____

Would you like information about heath care financing? _____

Signature of Patient or Representative: _____

Relationship: _____ Date: _____

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Information Reference

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

Name(s) of Representative: _____

Relationship: _____ Phone: _____

Health Information: _____ Financial: _____

Both: _____ None: _____

Message Preferences

Simple: Results Return Call / Confirm Appt. Detailed: Includes Heath and Financial Information

Name(s) of Representative: _____

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 releases and share animation and records regarding my care with doctors and other healthcare provides, insurance companies or financial agents.

Payment and Insurance

I understand that the doctor's relationship as a dental care provide 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 charges and fees are ultimately my responsibility from the date that any evaluations or services are rendered. I am encouraged to understand my dental benefits and I am 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 retuned checks. A fee may be charged if less than 48 hours is provided to change an appointment.

Signature of Patient or Representative: _____

Relationship: _____ Date: _____