PAUL B GABRIEL DMD, FICOI

2500 Brooktree Road
Suite 100
Wexford, PA 15090

Tele 724.935.2100

Please print all information

Date _____

Patient Name _____

Date of Birth _____

Sex _____ **SS#** _____

___Married ___Single __Minor __Divorced __Widowed __Partnered

Address _____

City, State, Zip _____

Home Phone _____ **Cell** _____

Work Phone _____**Ext** _____

Email _____

Driver's License # _____

INSURANCE SUBSCRIBER INFORMATION

Name of Insured _____

Date of Birth _____

SS# _____ **Relationship** _____

Insurance Company _____

Insurance Company Phone # _____

Employer _____

Group Number _____

Alternate ID _____

***If patient is a minor, please print the names of Parents / Guardians**_____

Emergency Contact _____

Phone # _____
Kindly give a phone number other than your own

Who may we thank for referring you_____

Who will be responsible for your account

_____ Self ____ Spouse ____ Parent ____ Other

Name_____

Address (if different than patient)

_____

_____

Previous Dentist _____

Date of last dental xrays _____

Reason for today's visit _____

ASSIGNMENT & RELEASE

I certify that I have read and understand the questions within this packet and have answered truthfully. I acknowledge that any questions that I had, have been answered to my satisfaction. I will not hold my doctor and staff responsible for any errors or omissions that I have made in the completion of this form.

Signature _____

FEES & PAYMENTS

We make every effort to keep down the cost of your care. You can help by paying upon completion of each visit. **Payment is due at the end of each appointment unless prior arrangements have been made**. Estimates are available upon request. Please remember that insurance is owned by the subscriber and the subscriber needs to become familiar with coverage and benefits. **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. Insurance is a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment.

X_____
Signature of Patient Date

X_____
Signature of Patient Date
This signature is on file is my authorization for the release of information necessary to process my dental claim. I hereby authorize payment to Dr. Gabriel of the benefits otherwise payable to me.

X_____
Signature of Patient Date
I acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions concerning this Notice.