JAMES V. TIGANI III, D.M.D., P.A.
1021 GILPIN AVE, SUITE 205
WILMINGTON, DE 19806
302-571-8740

PATIENT INFORMATION Today's Date _____

SECTION A Patient Information

Patient Name _____M___F___
First Middle Initial Last

Birthdate _____/_____/_____ S.S.N._____-_____-_____

Address_____ Home Phone # _____
_____ Work Phone # _____
_____ Cell Phone # _____
Email Address _____

Single _____ Married _____ Divorced _____ Widowed _____

Place of Employment _____

Occupation _____

Referred by _____

If you are completing this form for another person, what is your relationship? _____

SECTION B Spouse's Information

Name _____ M____ F____
First Middle Initial Last

Birthdate _____/_____/_____ S.S.N. _____-_____-_____

Address _____ Home Phone # _____
_____ Work Phone # _____
_____ Cell Phone # _____
Place of Employment _____

SECTION C Dental Insurance

*Do you have dental insurance coverage with **YOUR** employer?* YES _____ NO_____

Name of Insurance Company _____

Group # _____ ID # _____

Address_____ Phone Number _____

*Do you have dental insurance with **YOUR SPOUSE's** employer?* YES _____ NO _____

Name of insurance company _____

Group # _____ ID# _____

Address _____ Phone Number _____

James V. Tigani III, D.M.D., P.A.
1021 Gilpin Avenue, Suite 205
Wilmington, DE 19806
Phone: 302-571-8740 Fax: 302-571-8755

James V. Tigani III, D.M.D. **Kristin M. Tigani-Taylor D.D.S**

Financial Responsibility Policy

As a result of the many different and confusing insurance company reimbursement policies, it is necessary to have an easily understood financial responsibility policy.

- It is important for you to provide the office with complete insurance information for all carriers with who you are insured at the time of service. At each office visit we need you to show us your insurance card to insure that your current insurance information is on file.
- As a service to our patients, we will submit your insurance claim to your primary insurance company. Our office will provide the insurance company with all the information to help you receive maximum benefit from you insurance company. However, it is the patient's responsibility to know the insurance coverage and benefits limit of their particular policy.
- If a claim is denied, we will research why the rejection occurred and will either resubmit to insurance or bill you the appropriate balance. If the claim is denied a second time, the appropriate balance immediately becomes the responsibility of the patient and should be paid to us directly. You may then contact your insurance company for reimbursement.
- If the patient has coverage with a secondary insurance company, we will submit all secondary claims directly to that insurance company along with a copy of explanation of benefits from the primary insurance, benefits from the secondary insurance coverage will be paid directly to the patient.
- Insurance is a patient's benefit designed to assist the patient in their financial obligation to the office of James. V. Tigani III, D.M.D., P.A. The patient is the one receiving the dental service and therefore is ultimately responsible for all charges on the account regardless of any insurance coverage. This applies to everyone in the family who is treated in the office of James V. Tigani III, D.M.D., P.A.
- The office will collect the patient's deductible and the estimated balance after primary insurance payment at the time of service. After the primary insurance payment is received, the patient will be billed for any difference between the anticipated insurance payment and the actual insurance payment. If the insurance payment is greater than the estimation, we will either refund the amount to the patient or leave the credit balance on the patients account to be applied toward future treatment.
- In the event that the patient does not have insurance coverage, charges for service are due and payable at the time services are rendered, unless a signed financial agreement has been approved.

Insurance benefits are estimates only. I understand that I am responsible for any co-payment and deductibles, along with any procedure that my insurance company does not cover. I authorize the dentist to release any information, including diagnosis and records or treatment rendered to my family, or me during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist, insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered and any collection fees accumulated on my behalf or that my dependent. I am also responsible for any insurance claims not paid within 60 days of service.

_____ _____

Signature of Patient (parent if minor) or Responsible Party Date