DR. TOM KLOSTER
2215 Vine Street, Suite D, Hudson, WI 54016
(715) 386-9119

Patient Information

Patient Name:_____ Preferred Name:_____
Last First M

Address:_____

City:_____ State:_____ Zip:_____

Birthday:_____ Age:_____

Gender:_____

_____Married _____ Widowed _____Single _____Minor
_____Separated _____ Divorced _____Other

Contact Information

Home:_____ Work:_____ Cell:_____

Email: _____

In case of emergency, contact:

Name:_____ Relationship:_____

Phone Number:_____

Insurance Information

Primary Dental Insurance:_____ Employer:_____

Policy Holder:_____ Relationship to Patient:_____

Policy Holder Information: Date of Birth:_____ Member ID # or Social Security:_____

Secondary Dental Insurance:_____ Employer:_____

Policy Holder:_____ Relationship to Patient:_____

Policy Holder Information: Date of Birth:_____ Member ID # or Social Security:_____

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Financial Policy

All patients must complete our Information and Insurance form before seeing the doctor.

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy. This form must be signed prior to any treatment.

**Estimated patient portions are due at the time of service.*
**We Accept Cash, Check, Visa, MasterCard*

REGARDING INSURANCE

A) Your Insurance and You: Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. We will accept assignment of insurance benefits, however, we do require 50% of operative charges to be paid for at the time of service. The balance is your responsibility whether your insurance company pays or not.

B) Usual and Customary Rates: Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

FAILED APPOINTMENTS

Unless canceled, at least 24 hours in advance, our policy is to charge for failed appointments at the rate of an office visit. Please help us serve all of our patients better by keeping your appointment.

Thank you, for understanding our Financial Policy. Please let us know if you have questions or concerns.

I have read the Financial Policy. I understand and agree to this Financial Policy.

*X*_____ _____
Signature of Patient/Responsible Party *Date*