

Michael Gruber, DMD, FAGD  
Michela Russo, DDS  
Anthony T. Chin  
Periodontology Specialty Permit #3925



Alexa Gruber, DDS  
Marc J. Novak, DMD  
Edward Rockford, DMD

## **Welcome to Our Practice!**

We are committed to providing exceptional dental care to our patients in a compassionate, professional environment. The following information is provided to introduce you to our practice philosophy and policies.

### ***Appointments***

Appointments are scheduled so we can provide the most efficient care in a relaxed setting. We make every effort to honor time commitments and we appreciate patients extending us the same courtesy. Patients are reminded of their appointments 2-3 days in advance by email, text, or phone. Patients are kindly asked to confirm their appointment at least 48 hours prior to their appointment through the reminder method employed.

### ***New Patient Appointments***

We reserve 90 minutes for each new adult patient visit and 60 minutes for each new child visit. This allows time for us to listen to patient concerns and to properly diagnose and develop appropriate treatment plans.

### ***Continuing Care***

Our practice is focused on prevention and maintaining optimum oral health. We recommend comprehensive treatment and continuing care on an appropriate recall schedule.

### ***Urgent Care After Hours***

We accommodate patients of record who experience dental emergencies after hours. A patient of record is one who has been seen and treated in the office during the past 18 months. If you are a patient of record and have a dental emergency, you can call the office for information on how to contact us. An after hours fee may be charged.

### ***Children and Adolescents***

We are happy to start seeing children at or above the age of three. Parents are welcome to accompany their children in the operatories. We require that parents remain in the office with children under the age of 18 for the entire appointment. Failure to comply may result in the appointment being rescheduled.

### ***Cancellations and Missed Appointments***

We require 48 hours advance notice of a cancellation. Patients who do not provide 48 hours notice of a cancellation or who do not present for a scheduled appointment may be charged a fee. Patients who fail to present for a second appointment may be dismissed from the practice.

### ***Payments and Insurance***

Payment for treatment is due and payable the day services are rendered. It is our goal, however, to assist all of our patients in obtaining the dental treatment they deserve. As a result, we offer several payment options, including cash, check, credit card, and third party financing. For patients with dental insurance, we will file the appropriate claim forms.

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### **Patient Information**

Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State \_\_\_\_\_ Zip: \_\_\_\_\_

Home #: \_\_\_\_\_ Work #: \_\_\_\_\_ Mobile #: \_\_\_\_\_

Email: \_\_\_\_\_

Sex: M / F      Birth Date: \_\_\_ / \_\_\_ / \_\_\_\_\_      SS#: \_\_\_\_\_

Family Status (circle): Single Married Divorced Child      Spouse's Name: \_\_\_\_\_

How did you first hear about our office? (circle one):

Another Patient	Another Dental Office	Brochure	Online Search
Facebook	Work	School	Insurance Website
Sign -Drive by	Walk in	Other: _____	

Whom may we thank for referring you to our practice? \_\_\_\_\_

### **Person Responsible for Account**

Name of responsible party: \_\_\_\_\_

Relationship to patient (Circle): Self Spouse Parent Other: \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home #: \_\_\_\_\_ Work #: \_\_\_\_\_ Mobile #: \_\_\_\_\_

Email: \_\_\_\_\_

Birth Date: \_\_\_ / \_\_\_ / \_\_\_\_\_      SS#: \_\_\_\_\_

### **Contact Information**

What is the best way to communicate with you? Home Phone / Mobile Phone/ Text / Email

In the event of an emergency, whom should we contact? Name \_\_\_\_\_

Relationship \_\_\_\_\_ Home #: \_\_\_\_\_ Work #: \_\_\_\_\_ Mobile #: \_\_\_\_\_

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### **Insurance Information (Primary)**

Name of Insured: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Insured Birth Date: \_\_\_ / \_\_\_ / \_\_\_\_

Insurance Plan Name: \_\_\_\_\_ Insurance Co Phone #: \_\_\_\_\_

Claims Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Group #: \_\_\_\_\_ ID #: \_\_\_\_\_

### **Insurance Information (Secondary)**

Name of Insured: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Insured Birth Date: \_\_\_ / \_\_\_ / \_\_\_\_

Insurance Plan Name: \_\_\_\_\_ Insurance Co Phone #: \_\_\_\_\_

Claims Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Group #: \_\_\_\_\_ ID #: \_\_\_\_\_

### **Employment Information**

Employer Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

### **Cancellations and Missed Appointments**

We require 48 hours advance notice of a cancellation. Patients who do not provide 48 hours notice of a cancellation or who do not present for a scheduled appointment may be charged a fee. Patients who fail to present for a second appointment may be charged a fee or dismissed from the practice. After the first missed appointment, a letter will be mailed reiterating our policy and reminding the patient of the risk of dismissal should another appointment be missed.

**I have read the Cancellation and Missed Appointment Policy. I understand and agree to this Policy.**

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_