Patient Registration *(Please Print)*

Compass Point

DR. Yezerski

Patient's Name _____ Date of Birth _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Social Security Number _____

Name of Person Responsible for Payment _____

Relationship _____ Social Security Number _____

Home Address (if different from patient) _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Occupation _____ Employer _____

Spouses Name _____ Social Security Number _____

Spouses Occupation _____ Employer _____

Spouses Work Phone _____ Extension _____

Name of Dental Insurance _____

Name of Medical Insurance _____

Name of Dentist _____

Referred By _____

I authorize Dr. Yezerski to release any information pertaining to my treatment for purpose of insurance claim processing or to facilitate associated medical or dental care.

_____ _____

Patient's Signature Date

OUR PAYMENT POLICY

Payment is due on the day of surgery unless other definitive arrangements have been made. NO ACCOUNTS ARE CARRIED AFTER 90 DAYS.

We will be happy to assist you in filing your Insurance claim, however, it is your responsibility to provide our office with your Insurance forms at the time of your appointment. Please complete and sign the Patient Portion of the forms. ANY DIFFERENCE BETWEEN YOUR FEE AND THE AMOUNT YOUR INSURANCE PAYS IS YOUR RESPONSIBILITY.

Please keep in mind that your Insurance contract is between you and your Insurance Company, not the doctor. It is your responsibility to be familiar with and understand the terms, conditions and limitations of your contract.

I have read and understand the above Financial Policy and agree with these terms.

_____ _____

Signature of Person Responsible for Payment Date

7379 Pearl Road, Middleburg Heights, Ohio 44130
p.440-234-1810

Compass Point