Smiles of Atlanta
5685 Lake Placid Drive NE
Atlanta, GA 30342
Phone: 770.777.0808

tel. 770.777.0808
fax 770.777.1113

We appreciate the value of your time, just as you do! We strive for on-time appointments and a personal, high tech dental experience at each and every appointment. You will have Dr. Trizzino's undivided attention, as he sees only one patient in time. Our treatment fees are within the range of other area practices that also provide cutting edge dentistry. Another perk, and as a courtesy to our patients, we will file your insurance electronically and send any required supporting documentation. Additionally, we will accept assignment of benefits (if you like), allowing you to pay just your estimated portion at the time of service.

ADMINISTRATIVE

□ I understand Dr. Trizzino and his staff have reserved the allotted appointment time just for me. I will make every effort to keep my appointment. I will give at least two (2) working days notice for schedule changes. A broken-appointment fee may be assessed.

□ I agree to be responsible for payment of all services rendered on my behalf or to my dependents.

ACKNOWLEDGEMENT OF HIPPA Information

□ I acknowledge that I received a copy of Ed S. Trizzino, D.D.S. Notice of Privacy Practices.

DENTAL INSURANCE

We are happy to assist you in obtaining the maximum dental insurance benefits that your policy provides. Also, we will accept an assignment of benefits from your insurance carrier for the ***estimated*** *portion of your coverage.* ***Your estimated portion is due and payable at the time of service.*** *Also, we cannot be responsible for monitoring benefits, as that is up to the patient. If your insurance payment is not receive within 60 days from the date of service, your balance will be transferred to your credit card account. At that time, we will provide you the necessary paperwork to receive payment directly. Aging accounts of 60+ days are subject to a 1.5% finance charge.*

Remember, our professional Services are rendered to YOU, not your insurance company.

□ I authorize Serenity Dental to submit my dental claims electronically and to assign benefits to be paid directly to them. I understand that the insurance company's unpaid portion is my responsibility, and is guaranteed with credit card payment authorization to cover any outstanding balance remaining on my account for more than 60 days.

Credit Card Type: _____ **Expiration Date:** _____ **Account #:** _____

Information given is confidential and is for our office purposes only and will NOT be shared or distributed outside of this dental office.

CLINICAL CONSENT

□ I will update my (my dependent's) medical history as required.

□ I hereby authorize Dr. Trizzino or designated staff to take x-rays, study models, photographs and any other diagnostic aids as mutually agreed upon and deemed appropriate by the doctor to make a thorough diagnosis of my dental needs.

□ Upon such diagnosis, I authorize Dr. Trizzino to perform any mutually agreed upon treatment, and to employ such assistance as required to provide proper care.

□ I agree to the use of anesthetics, sedatives, and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

Patient Name: _____

Patient Signature (or Guardian if minor): _____ **Date:** _____

Print Your Name: _____