Insurance Information

Primary

Is Insured a patient? ◯ Yes ◯ No

Insured's Name ____________ LAST FIRST MI

Insured's Birth Date ____________

ID# ____________

Group # ____________

Insured's Address ____________ STREET

____________ CITY STATE ZIP

Insured's Employer Name ____________

Employer Address ____________ STREET

____________ CITY STATE ZIP

Patient's relationship to insured ◯ Self ◯ Spouse ◯ Child ◯ Other ______

Insurance Plan Name ____________

Insurance Plan Address ____________ STREET

____________ ( ) - CITY STATE ZIP PHONE

Secondary

Is Insured a patient? ◯ Yes ◯ No

Insured's Name ____________ LAST FIRST MI

Insured's Birth Date ____________

ID# ____________

Group # ____________

Insured's Address ____________ STREET

____________ CITY STATE ZIP

Insured's Employer Name ____________

Employer Address ____________ STREET

____________ CITY STATE ZIP

Patient's relationship to insured ◯ Self ◯ Spouse ◯ Child ◯ Other ______

Insurance Plan Name ____________

Insurance Plan Address ____________ STREET

____________ ( ) - CITY STATE ZIP PHONE

Referral Information

Whom may we thank for referring you to our practice?

◯ Another Patient ◯ Yellow Pages ◯ Dental Office

◯ Other ____________

Name of person referring? ____________

Office Notes ____________

Employment Information

The following is for ◯ the patient ◯ the person responsible for payment

Employer Name ____________ Phone ____________

Address ____________ STREET

____________ CITY STATE ZIP

Occupation ____________

Spouse or Responsible Party Information

The following is for ◯ the patient's spouse ◯ the person responsible for payment

Name ____________ LAST FIRST MI

Date ____________ Birthdate ____________

SSN# ___ - ___ - ___ ◯ Male ◯ Female

◯ Married ◯ Single ◯ Child

Phone (Home) ____________

Phone (Work) ____________ Best Time To Call ____________

Address ____________ STREET

____________ CITY STATE ZIP

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends on reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time the services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from the insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

In accordance with the Federal Truth-in-Lending Act, any balance older than 60 days will be subject to a billing charge of 5$ per month or finance charges of 21% APR, whichever is greater..

I understand that the fee estimate listed for this dental care can only be extended for a period of one month from the date of the patient's examination.

In consideration for the professional services rendered to me, or at my request, by the doctor, I agree to pay therefore the reasonable value of said services to said doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

X ____________

Signature of patient, parent of guardian Date

____

Relationship to Patient

X ____________

Signature of guarantor of payment/responsible party Date

____

Relationship to Patient