

Dental Insurance Information

Primary

Name of Insured: _____ Is insured a patient? Yes No

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____

Insured's Employer Name: _____

Address: _____

Patient's relationship to insured: Self Spouse Child Other: _____

Insurance Plan Name and Address: _____

Phone #: _____

Secondary (Additional Insurance)

Name of Insured: _____ Is insured a patient? Yes No

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____

Insured's Employer Name: _____

Address: _____

Patient's relationship to insured: Self Spouse Child Other: _____

Insurance Plan Name and Address: _____

Phone #: _____

Minor Patient's Responsible Party Information

Name: _____

Male Female

Relationship to minor patient

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____

Street _____ Apartment # _____

City _____ State _____ Zip Code _____

Consent for Services

As a condition of your treatment by this office, the patient is responsible for ensuring payment of the full fee charged for all treatment performed. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are performed. Patients who require special financial arrangements must notify us in advance.

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 insurance forms or assist in making collections from 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. **Estimates of patient co-pay amounts are not a guarantee of the final amount due which will be determined and billed after all insurance payments have been received.**

A service charge of 1% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied. If my account is secured by credit card, I hereby authorize any past due amounts to be charged to my securing card account.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient 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, as allowed by state law.

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 agree to their content.

_____ Date: _____ Relationship to Patient: _____

Signature of patient, parent or guardian