

Additional Insurance

Do you have any additional insurance? Yes No If yes, complete the following:

Name of insured _____

Relationship to patient _____

Birth date _____ Soc. Sec.# _____ Date employed _____

Name of employer _____ Work Phone _____

Address of employer _____ City _____ State _____ Zip _____

Insurance company _____ Group # _____

Ins. co. address _____ City _____ State _____ Zip _____

How much is your deductible? _____ How much have you used? _____ Max. annual benefit? _____

Authorization, Release, and Agreement to Pay For Services Rendered

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such Dental care to third party payors and/or other health practitioners.

I authorize and hereby request my insurance company to pay directly to the dentist (or the dental group) insurance benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents.

X

Signature of patient or parent if minor

Date

Financial Arrangements

For your convenience we offer the following methods of payment. Please check the option which you prefer. If you have any questions concerning financial arrangements or need special arrangements, please ask for assistance.

_____ Cash

_____ Personal Check

_____ Credit Card _____ Visa _____ MasterCard

Card # _____ Expiration Date _____

Late Charges

If I do not pay the entire new balance within 60 days of the monthly billing date, a late charge of 1.5% (or a minimum \$2.25) will be assessed each month. I realize that failure to keep this account current may result in your being unable to provide additional dental services except for dental emergencies, or where there is a prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.

Thank you for filling out this form completely. The information you have provided will help us serve your dental health care needs more effectively and efficiently. If you have questions at any time, please ask us. We are always happy to help.