



### SPOUSE OR RESPONSIBLE PARTY INFORMATION

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

Name: \_\_\_\_\_

Male  Female  Married  Single  Child  Other

Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ Ext: \_\_\_\_\_ Best time to call: \_\_\_\_\_

Address: \_\_\_\_\_  
Street Apartment #

City State Zip Code

### EMPLOYMENT INFORMATION

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

Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_

Street City State Zip Code

### INSURANCE INFORMATION

#### Primary

Name of Insured: \_\_\_\_\_ Is insured a patient?  Yes  No

Last First MI

Insured's Birth Date: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Insured's Address: \_\_\_\_\_

Street City State Zip Code

Insured's Employer Name: \_\_\_\_\_

Address: \_\_\_\_\_

Street City State Zip Code

Patient's relationship to insured:  Self  Spouse  Child  Other \_\_\_\_\_

Insurance Plan Name and Address: \_\_\_\_\_

#### Secondary

Name of Insured: \_\_\_\_\_ Is insured a patient?  Yes  No

Last First MI

Insured's Birth Date: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Insured's Address: \_\_\_\_\_

Street City State Zip Code

Insured's Employer Name: \_\_\_\_\_

Address: \_\_\_\_\_

Street City State Zip Code

Patient's relationship to insured:  Self  Spouse  Child  Other \_\_\_\_\_

Insurance Plan Name and Address: \_\_\_\_\_

### CONSENT FOR SERVICES

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon 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 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 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.

A service charge of 1 1/2% 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.

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.

I have read and understand the above information and conditions of treatment and payment. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist 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 to me or my dependents.

Signature of patient, parent or guardian Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Signature of guarantor of payment/responsible party Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_