

Responsible Party Information

Please complete the following if you are **NOT** the Responsible Party:

Name: _____
 Male Female Spouse Child Other _____
Social Security #: _____ Birth Date: _____
Phone (Home): _____ (Cell): _____ (Work): _____
Address: same as patient

Street City State Zip

Employment Information for Patient

Employer Name: _____ Employer Phone: _____
Employer Address: _____

Street City State Zip

Insurance Information

Primary

Policy Holder's Name: _____ Is policy holder a patient? Yes No

Last First MI ID #: _____ Group #: _____
Policy Holder's Birth Date: _____
Policy Holder's Address: _____
Street City State Zip Code
Policy Holder's Place of Employment: *If same as above check here* _____
Employer Address: _____
Street City State Zip Code
Patient's relationship to Policy Holder: Self Spouse Child Other _____

Insurance Plan Name and Address:

Secondary

Policy Holder's Name: _____ Is policy holder a patient? Yes No

Last First MI ID #: _____ Group #: _____
Policy Holder's Birth Date: _____
Policy Holder's Address: _____
Street City State Zip Code
Policy Holder's Place of Employment: _____
Employer Address: _____
Street City State Zip Code
Patient's relationship to Policy Holder: 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 1½% 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.

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.

Signature of patient, parent or guardian

Date: _____ Relationship to Patient: _____

Signature of guarantor of payment/responsible party

Date: _____ Relationship to Patient: _____