



## Spouse or Parent Information

Name: \_\_\_\_\_  
Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ Ext: \_\_\_\_\_ (Cell): \_\_\_\_\_  
Address: \_\_\_\_\_  
Street Apartment #  
City State Zip Code

## Insurance Information

### Primary

Name of Insured: \_\_\_\_\_  
Last First MI  
Insured's Birth Date: \_\_\_\_\_ ID #: \_\_\_\_\_ SS# \_\_\_\_\_ Group #: \_\_\_\_\_  
Insured's Address: \_\_\_\_\_  
Street City State Zip Code  
Insured's Employer Name/Address \_\_\_\_\_  
Patient's relationship to insured:  Self  Spouse  Child  Other \_\_\_\_\_  
Insurance Plan Name and Address: \_\_\_\_\_

### Secondary

Name of Insured: \_\_\_\_\_  
Last First MI  
Insured's Birth Date: \_\_\_\_\_ SS# \_\_\_\_\_ ID #: \_\_\_\_\_ Employer \_\_\_\_\_ 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 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. If your insurance company has not paid within 45 days, full payment is required from the guarantor immediately. **Our office will attempt to estimate your portion due; however, this is only an estimate. You are responsible for any charges your insurance company does not pay, which will be due from you after 30 days of non payment from insurance.**

**If you fail to show up for 2 appointments, and you do not notify the office in adequate time for the appointment to be filled, it will be required to pay a deposit for any future appointments.**

**A \$5.00 dollar billing fee will be charged to your account if we are required to send more than one statement to collect a fee.**

X \_\_\_\_\_ INITIAL

I understand a fee estimate listed for dental care can only be extended for a period of three months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, I agree to pay 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.

**I HAVE READ THE HIPAA NOTICE OF PRIVACY PRACTICES AND AGREE TO THE POLICY** X \_\_\_\_\_ INITIAL

To the best of my knowledge all of the preceding answers and information are true and correct. If I ever have any change in my health, insurance or financial information, I will inform the office without fail.

X \_\_\_\_\_ Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Signature of patient, parent, guardian or guarantor of payment/responsible party