## ***Parent or Guardian Information***

Name: Last _____ First _____Middle _____

Social Security #: _____ Date of Birth: _____

Phone#: _____Work/Cell#: _____

Address: Street _____ Apt# _____

City _____ State _____ Zip Code_____

## ***Employment Information***

Employer Name: _____

Address: _____

## ***Insurance Information***

***Primary***

Insurance Carrier Name: _____ Address for Insurance: _____

Name of Insured: _____ _____ Is insured a patient ◯ **Y** ◯ **N**

Insured's Birth Date: _____ID# _____ Group# _____ _

Insured's Employer: _____

***Secondary***

Name of Insured: _____ _ Is insured a patient ◯ **Y** ◯ **N**

Insured's Birth Date: _____ID# _____Group# _____ _____

Insured's Employer_____

### ***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 patient for the cost 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 or credit card at the time services are performed.

This office reserves the right to bill for missed or cancelled appointments with less than 24 hours' notice.

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 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 30 days and a late fee of $25 will be imposed, unless previous financial arrangements are made. If my account is passed on to an outside collection agency the account holder will be responsible for the 30% imposed to collect the balance.

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. 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 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.

_____ Date_____ Relationship to Patient_____

Signature of Patient, Parent or Guardian