RESPONSIBE PARTY

The following is for: ☐ the patient ☐ the patient's spouse ☐ the patient's parent

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 ☐ responsible party

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: _____

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. Assistance with dental insurance is a courtesy and is not a contractual obligation of this office.

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.

The total payment of by bill is my legal obligation as the patient. Should this account be placed in the hands of an attorney for collection, I agree to pay attorney fees of thirty-three and one-third percent of the unpaid principal and interest that is or becomes due, plus all court costs, and interest in the amount of one and one-half percent per month, beginning 60 days after the moneys have become due or expenses have been incurred. I further agree to pay returned check charges of $25 per returned check.

I understand that any patient who agrees to undergo a medical procedure that has the potential for blood or body fluid exposure, agrees to have his/her blood tested for human immunodeficiency virus and hepatitis virus ("HIV/HBV/HCV") should a health care worker be exposed to the patient's blood or body fluid during the procedure. Conversely, any patient who is exposed to the blood or body fluids of a health care worker, during a medical procedure, has the right to have that worker's blood tested for HIV/HBV/HCV. In both cases, the person exposed has a right to the results of the test.

I grant my permission to release medical or dental information to insurance carriers or to other physicians or dentists who may need this information to aid in the processing of my claims or in my care.

I understand that I will be financially responsible for charges for broken or missed appointments or appointments which are canceled without giving at least 24 hours notice during regular business hours of this office.

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

_____ Date:_____ Relationship to Patient: _____

Signature of guarantor of payment/responsible party