

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? Yes No

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____

Insured's Employer Name: _____

Address: _____

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan Name and Address: _____

Secondary

Name of Insured: _____ Is insured a patient? Yes No

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____

Insured's Employer Name: _____

Address: _____

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan Name and Address: _____

Consent for Services

I consent to the performing of dental and oral surgery procedures including the use of local anesthetic as indicated.

I accept that all emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time the services are performed.

I understand that I am to pay my estimated patient portion at the time of my treatment and that I am financially responsible for any and all further charges not paid for by my dental insurance. As a professional courtesy this office will prepare the patients insurance forms, make collections from insurance companies and will credit any such collections to the patient's account. However, if the insurance information provided to us is incorrect this office cannot be responsible for outstanding balances. Any outstanding balances are the sole responsibility of the patient.

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.

I authorize the insurance company indicated on this form to pay the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I understand that the information gathered on this form and in subsequent visits may be used to contact me at my home or work to discuss matters related to this form, discuss treatment needs or outcomes, and correspond with other health care providers who may participate in my treatment. Digital photos and x-rays may be used for educational purposes or presentations while guaranteeing my anonymity. My personal information will not be given to anyone for any other purpose.

I accept that a service charge of **\$50.00** will be billed to patients that do not give at least **48 hours notice** to change or cancel a scheduled appointment.

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: _____