Employment Information

The following is for ____ the patient's spouse ____ the person responsible for payment

Employer Name: _____ Occupation: _____
Address: _____

Insurance Information

Primary
Name of Insured: _____ Is insured a patient? _____
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? _____
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: _____
_____

For office use only:

Eligibility Verified on ____ / ____ / ____ By _____ Contact: _____

Max _____ Deductible _____ Family _____ Waiting Period _____

Prevent _____ Basic _____ Major _____ Periodontics _____

Flouride _____ Inlay/Onlay _____ Pan/FMX _____ Prophy Frequency _____

Age Limits _____ Ortho _____ Implants _____ Other _____

Notes: _____

_____

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 preformed.

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.

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.

_____ Date: _____ Relationship to patient: _____
Signature of patient, parent or guardian