

## Responsible Party Information

Name \_\_\_\_\_  
Last First MI  
( ) Male ( ) Female ( ) Married ( ) Single ( ) Divorced ( ) Other  
Phone (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Cell) \_\_\_\_\_  
Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Address \_\_\_\_\_

## Primary Insurance Information

Name of Insured \_\_\_\_\_  
Last First MI  
Relationship to the patient: ( ) Self ( ) Spouse ( ) Child ( ) Other  
Date of Birth \_\_\_\_\_ ID# \_\_\_\_\_ Group# \_\_\_\_\_  
Address \_\_\_\_\_  
Name of Employer and Address \_\_\_\_\_  
Insurance Plan Name and Address \_\_\_\_\_

**I hereby authorize payment of dental benefits otherwise payable to me directly to the above names dental entity.**

Signed \_\_\_\_\_ (Employee/Insured Subscriber) Date \_\_\_\_\_

## Consent For Services

As a condition of your treatment by this office, financial arrangements must be made in advance. Patients who carry dental insurance understand that he/she is personally responsible for the payment of all dental services that are not covered by their insurance.

In addition, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. If we were to bill the insurance company, he/she must have a valid ID and current insurance card and benefit information. If you cannot provide those items at the time of check-in, we will not provide service.

This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit and such collections to the patient's account. If we do not receive payment from your insurance within 60 days, YOU ARE RESPONSIBLE FOR THE BALANCE. We do not file secondary insurance. All patients fees are due in full the day of service. Payment can be made by cash, check, or credit card. We do not accept American Express. Insurance patients pay their deductible and their percentage on the day of service.

Return check policy: There will be a \$30.00 return check charge.

If there are collection problems, I understand that I am responsible for all collection fees including attorney fees, court costs, and late charges.

I agree to be responsible for all charges for dental services and materials not paid by dental benefit plan, unless the treating dentist has a contractual agreement with my plan prohibiting all or a portion of such charge. To the extent permitted under applicable law, I authorize release of any information relating to this claim.

Signed \_\_\_\_\_ (Patient or Responsible Party) Date \_\_\_\_\_