

All Fields Marked in **BOLD** are **REQUIRED** Information

Patient Last Name _____ **Patient First Name** _____
Street _____ **Street2** _____
City _____ **State:** _____ **Zip:** _____ **Sex:** [M] [F] **Marital Status:** [] single [] married [] divorced [] other
Date of Birth: _____ **Social Security Number** _____
E-Mail Address: _____
Home Phone () _____ **Work Phone: ()** _____ **Cell Ph:()** _____
I am : [] Full Time Employed [] Full Time Student [] Part-Time Student [] Unemployed /Retired

School or Employer's Name: _____
Who Referred you? _____ [] I was sent at the request of my attorney or insurance company
Is **Patient Responsible** for payment? [yes] [no] If YES then skip this section. IF NO then you MUST complete the following information

Relationship to Patient: Circle One (Father Mother Wife Husband Guardian other) _____ **Divorced [y] [n]**
Guar. Last Name _____ **Guar.First Name** _____
Street _____ **Street2** _____
City _____ **State:** _____ **Sex [M] [F]**
Date of Birth _____ **Social Security Number** _____
Home Area Code / Phone () _____ **Work Area Code / Phone ()** _____

Dental Insurance Information:

Dental Insurance Company: _____ **Plan Name:** _____
Insurance ID Number _____ **Group Name/Number** _____
Address _____ **City** _____ **State** _____ **Zip** _____
Is the Patient the Policy Holder [y] [n] If you checked NO you must give policy holder information
Relationship of Policy Holder to Patient [] mother [] father [] wife [] husband [] other.. _____
Policy Holder First Name _____ **Last Name** _____
Address _____ **City** _____ **State** _____ **Zip** _____
Area Code + Phone _____ **SS#** _____ **Date of Birth** _____ **Employer** _____

Medical Insurance Information

Medical Insurance Company Name: _____ **Plan Name:** _____
Insurance ID Number Group Name/Number _____
Address _____ **City** _____ **State** _____ **Zip** _____
Is the Policy Holder Information the Same as the Dental Insurance Policy Holder Information? If YES skip next section.
Relationship of Policy Holder to Patient [] mother [] father [] wife [] husband [] other.. _____
Policy Holder First Name _____ **Last Name** _____
Address _____ **City** _____ **State** _____ **Zip** _____
Area Code + Phone _____ **SS#** _____ **Date of Birth** _____ **Employer** _____

READ THIS !!!

Insurance coverage is your responsibility not ours. Some services or procedures may not be covered by your insurance or third party carrier. The Claims not paid within 30 days are billed to the patient. We do not and will not resubmit claims. If you do not provide us accurate and complete information then you are responsible for payment of all professional fees, and we will not be bound by any prior contractual arrangement with any third party.

All unpaid balances over 30 days are subject to interest and finance charges of 1.5% per month compounded daily. There is a statement fee of 15.00 per statement. The guarantor is responsible for payment of any and all attorney, secretarial and court fees associated with collection of any unpaid balances. I agree to the use of a facsimile of my signature below for the purpose of all third party reimbursement and claims review. I agree to the release of my medical records to any third party or insurance carrier for purposes of obtaining reimbursement. I have read the financial agreement. I have had the opportunity to ask questions regarding the agreement. I read and understand English. I agree to be responsible for payment of all professional fees.

Patient Signature: _____ **Date:** _____

Guarantor (must be over 18) Signature: _____ **Date:** _____

Printed Guarantor Name: _____