

Dental and Medical Insurance Information

Dental

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: _____

Medical

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/Payment Policy

The undersigned hereby authorizes doctor to order x-rays, study models, photographs and/or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs. I authorize doctor to perform all recommended treatment mutually agreed upon and to use the appropriate medication and therapy indicated for such treatment. I authorize and consent that doctor chooses and employ such assistance as deemed fit to provide recommended treatment. Following diagnosis I'll be informed on findings and advised of the suggested treatment plan. After mutual agreement on the treatment plan, treatment will be rendered.

Initials

As a condition of my treatment, financial arrangements must be made in advance. I'll be presented various financial options and given an opportunity to select the plan that best suits my needs. All emergency dental services, or any dental services rendered without previous financial arrangements, must be paid for at the time services are rendered. 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 examination, unless the fees have been changed by my insurance carrier sooner. I understand that all dental services furnished are charged directly to me and I'm personally responsible for payment for such services. This office will help me prepare all insurance forms and assist in making collections from insurance companies, and will credit any such collections to my account. However, this dental office cannot render services on the assumption that all charges will be paid by an insurance company. Should the insurance company decide not to contribute or pay less than the "guesstimate", I, the patient, will be responsible for any difference owed.

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, if user arrangements was not made, I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within 30 days after treatment is rendered. 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 will be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home, on cell phone, or at my work to discuss matters related to this form.

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any changes in my health status or information on these forms, I will inform the doctor at the next appointment without fail.

I have read the above conditions of treatment and payment and agree to their content. I authorize to use and disclose my medical information for the purposes of Treatment, Payment and Health Care Operations.*

You may review our "Notice of Privacy Practices" for additional information about the uses and disclosures of information described in this Consent. Please verify that you have received a copy of our Notice by placing your initials here: _____

Signature of patient, parent or guardian

Date: _____

Signature of guarantor of payment/responsible party

Date: _____