PATIENTS NAME _____

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT _____ Relationship to Patient _____

Address _____ Home Phone _____

Drivers License # _____ Birthdate _____ Soc. Sec. # _____

Employer _____ Work Phone _____

Is this person currently a patient in our office? Yes _____ No _____

INSURANCE INFORMATION

PRIMARY DENTAL INSURANCE CO.

Name of Insured _____

Relationship to Patient _____

Insured's Birthdate _____

Soc. Sec. # _____

Employer _____

Insurance Co. _____

Ins. Co. Address _____

City _____ State _____ Zip _____

Telephone _____ Group # _____

SECONDARY DENTAL INSURANCE CO.

Name of Insured _____

Relationship to Patient _____

Insured's Birthdate _____

Soc. Sec. # _____

Employer _____

Insurance Co. _____

Ins. Co. Address _____

City _____ State _____ Zip _____

Telephone _____ Group # _____

Financial Arrangements

For your convenience, we offer the following methods of payment. Please check which option

How will you be paying for your visit? Cash _____ Check _____ Credit Card _____

If I do not pay the entire new balance within 30 days of the monthy billing date, a late charge of 1.5% will be applied to the unpaid balance. I realize that failure to keep this account current may result in our office being unable to provide any additional services, other than emergencies or where there is prepayment made first. In the case of default on payment of this account, I agree to pay collection costs incurred in attempting to collect on this account or future outstanding account balances.

To the best of my knowledge, all the preceding answers are true and correct. If I ever have any change in my health, or if my medicines change, I will inform the dentist at my next appointment. I authorize the Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of my dental needs. I understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment is mine, due and payable at the time services are rendered. I further understand that a finance charge will be added to any overdue balance. I also assign all insurance benefits to the Doctor.

_____

Date Patient Signature, Parent or Guardian Dentist Signature