BILLING AND INSURANCE INFORMATION

Date _____

Patient Name _____ Nickname _____ Birthdate _____
Billing Address _____ Home Phone _____ Work Phone _____
City _____ State _____ Zip _____ Cell Phone _____
Social Security # _____ E-mail: _____
Employer: _____ Occupation: _____

FINANCIAL ARRANGEMENTS - Financial arrangements are made prior to treatment. Our fees remain the same independent of insurance coverage. All returned checks are subject to a reprocessing fee of $15.00.

Without dental insurance, full payment is required at the same time of treatment. If you have dental insurance coverage, the difference between total fees and estimated insurance payment will be due at the time of treatment. You will receive a current monthly statement, even though your insurance carrier may not have paid yet. When payment is received from your insurance, your next statement may reflect a balance due.

APPOINTMENT POLICY
We respect that your time is valuable and we will exclusively reserve appointment times for you. We expect that you honor these times. If your prescheduled appointment becomes inconvenient, please notify us at least 48 hours in advance and we will gladly change it. **One "No Show" appointment will result in an assessed fee of $50.00.**

NOTE - Please sign below to indicate that you have read and understand our office policy. We will be happy to answer any questions you may have.

Date _____ Signature _____

PRIMARY INSURANCE

Subscriber's Employer _____ Work Phone # _____
Insurance Company _____ Group # _____
Subscriber's Name _____ Insurance Phone # _____
Address (if different than patient) _____
City _____ State _____ Zip _____ Subscriber's Birthdate _____
Subscriber's Social Security # _____ Patient's Relationship to Subscriber ❑ Self
Insurance Id # _____ ❑ Spouse ❑ Child ❑ Other _____

SECONDARY INSURANCE

Subscriber's Employer _____ Work Phone# _____
Insurance Company _____ Group # _____
Subscriber's Name _____ Insurance Phone # _____
Address (if different than patient) _____
City _____ State _____ Zip _____ Subscriber's Birthdate _____
Subscriber's Social Security # _____ Patient's Relationship to Subscriber ❑ Self
Insurance Id # _____ ❑ Spouse ❑ Child ❑ Other _____

NO INSURANCE

PERSON RESPONSIBLE
Name _____ Address _____
Home Phone _____ Work Phone _____
Relationship to Patient _____

FAMILY MEMBERS	First Name	M.I.	Last Name	Birthdate Mo/Day/Yr	Social Security Number	Current Patient
Male : Head of Household						❑ Yes ❑ No
Female : Head of Household						❑ Yes ❑ No
Dependents: 1:						❑ Yes ❑ No
2:						❑ Yes ❑ No
3:						❑ Yes ❑ No
4:						❑ Yes ❑ No