Additional Insurance

Do you have any additional insurance? ☐ Yes ☐ No If yes, complete the following:

Name of insured ______________________

Relationship to patient ______________________

Birthdate ____________ SS #/SIN ____________ Date employed ____________

Employer ______________________ Work phone ____________

Address of employer ____________ City ____________ State/ Prov. ________ Zip/ P.C. ________

Insurance company ____________ Group # ____________ Employer/cert. # ____________

Ins. co. address ____________ City ____________ State/ Prov. ________ Zip/ P.C. ________

How much is your deductible? ________ How much have you used? ________ Max. annual benefit? ________

Authorization, Release, and Agreement to Pay For Services Rendered

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such Dental care to third party payors and/or other health practitioners.

I authorize and hereby request my insurance company to pay directly to the dentist (or the dental group) insurance benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actucl bill for services. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents.

X ______________________________ ____________

Signature of patient or parent/guardian if minor Date

Financial Arrangements

For your convenience, we offer the following methods of payment. Please check the option which you prefer. If you have any questions concerning financial arrangements or need special arrangements, please ask for assistance.

Payment in full at each appointment

______ Cash

______ Personal Check

______ Credit Card ______ Visa ______ MasterCard

Card # ______________________ Expiration Date ____________

Late Charges

If I do not pay the entire new balance within 25 days of the monthly billing date, a late charge of 1.5% on the balance then unpaid and owed will be assessed each month (if allowed by law). I realize that failure to keep this account current may result in you being unable to provide additional dental services except for dental emergencies or where there is prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.

Thank you for filling out this form completely. The information you have provided will help us serve your dental healthcare needs more effectively and efficiently. If you have any questions at any time, please ask us. We are always happy to help.

Item 053-0311/9053 Patterson Office Supplies 800-637-1140