ACCOUNT INFORMATION

PATIENT NAME: _____ DATE(S) OF BIRTH: _____

_____ _____

_____ _____

_____ _____

ADDRESS: _____

PARENT/GUARDIAN NAME: _____ DATE OF BIRTH: _____

RELATIONSHIP TO CHILD: _____ SS# _____

ADDRESS (if different from child): _____

CELL #_____ HOME # _____ WORK# _____

EMAIL: _____

PARENT/GUARDIAN NAME: _____ DATE OF BIRTH: _____

RELATIONSHIP TO CHILD: _____ SS# _____

ADDRESS (if different from child): _____

CELL #_____ HOME # _____ WORK# _____

EMAIL: _____

HOW DID YOU HEAR ABOUT OUR OFFICE? _____

DENTAL INSURANCE

We require a copy of your dental insurance card AT EVERY VISIT. If you are unable to provide us with current information, we will collect payment at time of service and reimburse you once proper documentation is received. Thank you for your understanding.

PRIMARY DENTAL INSURANCE: _____EMPLOYER:_____

INSURANCE COMPANY ADDRESS (for dental claims): _____

GROUP#_____ ID#_____ SS# _____

POLICYHOLDER: _____ DATE OF BIRTH: _____

WE ONLY FILE SECONDARY CLAIMS FOR ANTHEM AND DELTA DENTAL

SECONDARY DENTAL INSURANCE: _____ EMPLOYER: _____

INSURANCE COMPANY ADDRESS (for dental claims): _____

GROUP#_____ ID#_____ SS# _____

POLICYHOLDER: _____ DATE OF BIRTH: _____

I understand that as the parent/guardian I am responsible for total payment of all services performed. Balances over 90 days, regardless of insurance coverage, will be subject to 1.5% monthly service charge (minimum $1.00), 18% APR, plus a $5 monthly billing charge. If the account is turned over for legal collection, I agree to pay for all collection costs including attorney's fees.

ACCOUNT POLICIES

We are very pleased you have chosen us to provide dental care for your child. The health and comfort of your child is our main concern.

THE PERSON WHO BRINGS THE CHILD TO OUR OFFICE FOR THE INITIAL VISIT AND SIGNS THIS FORM WILL BE THE PERSON RESPONSIBLE FOR THIS ACCOUNT.

INITIAL HERE_____

Our office will not become involved with any custody or court orders requiring another party to be responsible. Those issues must be worked out by the parties involved. A new form must be signed for us to transfer responsibility to another person. INITIAL HERE _____

In our continuing efforts to reduce the cost of dentistry for our patients, we are in the process of eliminating billing from our practice. We have several methods of payment available and we will be happy to help you choose the method that is the most comfortable for you.

PAYMENT OPTIONS:

1. PAYMENT IN FULL AT THE TIME OF SERVICE

We accept cash, check, Master Card, VISA, DISCOVER & AMERICAN EXPRESS. This method entitles you to a 5% discount on any treatment over $300, when requested at the time of check-out.

2. VERIFIED ESTIMATED INSURANCE CO-PAYMENTS

As a courtesy to our patients, we are happy to file insurance claims for services rendered.

We will file claims for all insurance companies (EXCEPT FOR ANY MEDICAID POLICIES, HMOs or DMOs) but we only participate in-network with ANTHEM and DELTA DENTAL. If you are out of network this means there may be a difference in fees from what your insurance company pays and what we charge. Insurance pre-authorizations are done prior to any work besides check-ups so you know exactly what your out of pocket expense will be. These can take up to 4 weeks to be processed by your insurance company.

Complete insurance information must be provided at the appointment or payment in full will be expected. We require all estimated co-payments to be made at the time of service. Insurance companies offer many plans and can change often. They are often based on fee schedules that they will not share with the dental office. We will make every effort to accurately estimate your payment due. We will file with your primary carrier, but can only file a secondary claim if your secondary carrier is Delta Dental or Anthem.

I certify that I read and understand all policies reviewed above and understand my responsibility.

NAME: _____ SIGNATURE: _____

RELATIONSHIP TO CHILD: _____ SS# _____ DATE: _____