# FINANCIAL & INSURANCE INFORMATION

**Patient Name**: ___________________________ **Patient SSN**: ________________ **Patient Birthdate**: ____/____/____

**Primary Insurance** Medical Coverage? ☐ Yes ☐ No Dental Coverage? ☐ Yes ☐ No

Insurance Co. Name: _________________________________ INS Phone #: (_____)______________ Group #: ________________________

Insurance Co. Address: ____________________________________________________________________________________________
Street/ PO Box City State Zip

Insured's Name: ____________________________ Insured's SSN: _________________ Insured's Birthdate: ___/___/___ Relation: _______

Insured's Employer: __________________________ Employer's Address: _________________________________________________________
Street/PO Box City State Zip

**Secondary Insurance** Medical Coverage? ☐ Yes ☐ No Dental Coverage? ☐ Yes ☐ No

Insurance Co. Name: ________________________________ INS Phone #: (_____)_______________ Group #: ________________________

Insurance Co. Address: ____________________________________________________________________________________________
Street/ PO Box City State Zip

Insured's Name: ____________________________ Insured's SSN: _________________ Insured's Birthdate: ___/___/___ Relation: _______

Insured's Employer: __________________________ Employer's Address: _________________________________________________________
Street/PO Box City State Zip

## AGREEMENT TO PAY FOR TREATMENT

The patient and responsible party listed below hereby agree to pay all charges submitted by this office during the course of treatment for the patient. If the patient has insurance coverage with an insurance company with whom this office has a contractual agreement, the patient and/or responsible party agree to pay all applicable co-payments and deductibles AT THE TIME OF TREATMENT. The patient and/or responsible party also agree to pay for treatment rendered to patient which is not considered to be a covered service by third party insurers or payors.

______________________________________________________
Signature Date

My method of payment will be: ☐ Cash ☐ Check ☐ Credit Card #: ___________________________________ Expiration Date: _______

______________________________________________________
Signature Date

If I do not pay the entire balance within 10 days of the monthly billing date, a late charge of 1.5% on the balance then unpaid and owed will be assessed each month (as allowed by law). I realize that failure to keep this account current may result in my being unable to receive additional services except for emergencies or when there is prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs and attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.

## RELEASE AND STATEMENT TO PERMIT OF PRIVATE OF PRIVATE INSURANCE BENEFITS TO PROVIDER

I, (We), the undersigned patient and/or responsible party hereby jointly authorize this office, its agents/employees to release and disclose all or any part of the patients' dental / medical records to any entity which is, or may be liable, for all or part of the provider charges.(insurance company)

I, (We), authorize the release and disclosure of any and all of my dental / medical records to any other entity, including, but not limited to, referring dentists or physicians, hospitals, or other health care providers, which may be of assistance in the opinion of this office, in providing for the treatment of the patient.

I, (We), authorize the release of records necessary to assist in the reimbursement of benefits to which I, (We) may be entitled. I, (We) authorize this office and/or its employees to release, via fax machine or email any dental / medical records which are needed in order to provide patient with the most appropriate dental care.

I, (We), authorize and request that payment of that payment of any third-party or insurance company benefits be made to this office for any services furnished below shall suffice for all insurance forms on a continuing basis. This is called 'assignment of benefits"

______________________________________________________ ______________________________________________________
Signature of Patient Date Signature of Insured Date