

Spouse or Responsible Party Information

The following is for: the patient's spouse the person responsible for payment

Name: _____
 Male Female Married Single Child Other _____

Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment #
City State Zip Code

Employment Information

The following is for: the patient the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City State Zip Code

Insurance Information

Primary

Name of Insured: _____ Is the insured a patient? Yes No

Insured's Birth Date: _____ ID #: _____ Group #: _____
Last First MI

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____
Address: _____
Street City State Zip Code

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan Name and Address: _____

Secondary

Name of Insured: _____ Is the insured a patient? Yes No

Insured's Birth Date: _____ ID #: _____ Group #: _____
Last First MI

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____
Address: _____
Street City State Zip Code

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan Name and Address: _____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursements from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

Payment is required for services rendered at the end of each and every appointment. We accept cash, Interac, Visa and Mastercard and personal cheques (with photo I.D.) NSF charge is \$15.

We accept assignment of insurance benefits for major procedures only. For major dental work we require full co-payment at the time of your first appointment. All basic procedures must be paid in full at the time the services are completed. We will send your claim electronically and your insurance company will reimburse you.

It is the patients' responsibility to track their annual insurance limits and to inform us of any changes. Upon their interpretation of the new privacy of information act, many insurance carriers will not give us information about your dental benefits. As a result, it is difficult to accurately determine what the out of pocket costs for our services will be and the patient is ultimately responsible for payment for services not covered by the insurance company.

We require two working days notice to make any changes to your appointment in order to avoid the cancellation/no-show charge.

I authorize the dentist to submit my claim electronically to my insurance company so that the payment will be received in a timely manner.

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental assessment and care. Where applicable, I authorize release of any information concerning my (or my child's) health care, advice and treatment to another dentist or specialist.

I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent or guardian Date: _____ Relationship to Patient: _____