

PERSONAL & CONFIDENTIAL INFORMATION

(Please Print)

Today's Date: _____

PATIENT'S LAST NAME: _____ FIRST: _____ M.I. _____
Home Phone #(____) _____ Sex: M F
Work Phone #(____) _____ Birthdate: _____ Age: _____
Street or Mailing Address: _____ Patient's Employer or School (if a student): _____
City: _____ State: _____ Zip: _____ Patient's Social Security #: _____

PERSON RESPONSIBLE FOR FEES (GUARANTOR) *If different from above *

Name: _____ Home Phone#(____) _____ Work Phone#(____) _____
Address: _____ City: _____ State: _____ Zip: _____
Employer: _____ Social Security#: _____ Birthdate: _____

Primary Dental Insurance Company _____ Group# _____
Employee/Subscriber Name _____ Relationship to Patient _____
Employer _____ Soc. Security/ID# _____ Birthdate: _____

Secondary Dental Insurance Company _____ Group# _____
Employee/Subscriber Name _____ Relationship to Patient _____
Employer _____ Soc. Security/ID# _____ Birthdate: _____

Primary Medical Insurance Company _____ Group# _____
Employee/Subscriber Name _____ Relationship to Patient _____
Employer _____ Soc. Security/ID# _____ Birthdate: _____

Secondary Medical Insurance Company _____ Group# _____
Employee/Subscriber Name _____ Relationship to Patient _____
Employer _____ Soc. Security/ID# _____ Birthdate: _____

Emergency Contact _____ Phone# _____
Relationship to Patient _____

Your Dentist's Name _____ Your Physician's Name _____
Orthodontist Name _____ Other Specialist _____

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing, and processing of insurance for benefits for which I am entitled. I will not hold Dr. Marsh, Dr. Crawford, Dr. Cooper or any members of their staff responsible for any errors or omissions that I may have made in the completion of this form.

SIGNATURE OF PATIENT _____ DATE _____
(Parent or Guardian if under 18 years old)

Office Policy Regarding Payment for Treatment

Payment Plans Available: I understand that payment is expected at the time services are rendered. I will pay according to the method indicated (please initial one).

_____ 1. I will pay **ALL** fees at the time of treatment by cash, check, Visa or Mastercard.

_____ 2. (For insurance coverage) I will pay the amount quoted to me as my estimated 'co-payment' at the time of treatment with the following agreement:

Your insurance coverage is a contract between you and your insurance company. If we have the necessary information, we will be glad to assist you in the submission of your claim, but payment of your account is ultimately your responsibility. Any fees left unpaid by your insurance are payable by you in full upon receipt of your statement of account. We cannot accept responsibility for collecting your insurance claim for you or negotiating a disputed claim. **You are responsible for payment of the balance of your account regardless of payment from insurance after 60 days from your initial date of treatment.** Insurance coverage is not a guarantee of payment! Insurance plans vary widely in their policy provisions and benefit amounts, therefore the amount quoted as your co-payment should not be relied upon to be your total balance due. We can only **estimate** your coverage and co-payment, so your understanding of your policy is your best assurance that your claim will be properly administered.

I authorize my insurance company to release benefits to my doctor that would otherwise be paid to me. I also authorize the doctor to release any information required for the administration of my claims.

SIGNATURE OF PATIENT _____ **DATE** _____
(Parent or Guardian if under 18 years old)

THERE IS A SERVICE CHARGE OF 1.5% PER MONTH ASSESSED ON ANY ACCOUNT BALANCE OVER 60 DAYS WITH A MINIMUM CHARGE OF \$1.00 PER MONTH.

I have read and I understand the terms of payment as outlined above. I agree that in the event I default and do not make payment in accordance with the terms indicated above, my account will be transferred to a collection agency, and that I will be responsible for the costs of collection including reasonable attorney's fees in an amount that can be 33% of the principal amount sued upon. I understand that there is a minimum \$30 service charge for any NSF check returns and that future payments will be cash only.

SIGNATURE OF PATIENT _____ **DATE** _____
(Parent or Guardian if under 18 years old)