

Cascade Periodontics

SPOUSE or RESPONSIBLE PARTY INFORMATION

The following is for: the patient's spouse the person responsible for payment
Name: (Last) _____ (First) _____ (MI) _____ Date: _____
 Male Female Married Single Child Other
Social Security #: _____ - _____ - _____ Date of Birth: _____
Phone: (Home) _____ (Work) _____ Ext. ____ (Cell) _____ Best time to call: _____
Address: _____ Apt.# ____ City: _____ State: _____ Zip: _____

EMPLOYMENT INFORMATION

The following is for: the patient the person responsible for payment
Employer name: _____ Occupation: _____
Address: _____ City: _____ State: _____ Zip: _____

INSURANCE INFORMATION

Primary

Name of insured: (Last) _____ (First) _____ (MI) _____ Is insured a patient? Yes No
Insured's date of birth: _____ ID#: _____ Group #: _____
Insured's address: _____ City: _____ State: _____ Zip: _____
Insured's employer's name: _____
Address: _____ City: _____ State: _____ Zip: _____
Patient's relationship to insured: Self Spouse Child Other _____
Insurance plan name and address: _____

Secondary

Name of insured: (Last) _____ (First) _____ (MI) _____ Is insured a patient? Yes No
Insured's date of birth: _____ ID#: _____ Group #: _____
Insured's Address: _____ City: _____ State: _____ Zip: _____
Insured's Employer's Name: _____
Address: _____ City: _____ State: _____ Zip: _____
Patient's relationship to insured: Self Spouse Child Other _____
Insurance plan name: _____
Address: _____ City: _____ State: _____ Zip: _____

CONSENT FOR SERVICES

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

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1 __% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 90 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of three months from the date of patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

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

Signature of guarantor of payment/responsible party /Date /Relationship to Patient