

### 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 \_\_\_\_\_  
Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_\_  
Phone (home) \_\_\_\_/\_\_\_\_/\_\_\_\_ (work) \_\_\_\_/\_\_\_\_/\_\_\_\_ Best time to call \_\_\_\_\_  
Address \_\_\_\_\_  
Street Apt. #  
City State Zip

### Employment Information

The following is responsible for payment:  The patient  The person

Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Address: \_\_\_\_\_  
Street City State Zip

### Insurance Information

#### Primary

Name of Insured: \_\_\_\_\_ Is insured a patient?  Yes  No

Insured's Birth Date: \_\_\_\_\_ ID# \_\_\_\_\_ Group # \_\_\_\_\_  
Insured's Address: \_\_\_\_\_  
Street City State Zip

Insured's Employer Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Street City State Zip

Patient's relationship to Insured:  Self  Spouse  Child  Other \_\_\_\_\_  
Insurance Plan Name and Address: \_\_\_\_\_  
\_\_\_\_\_

#### Secondary

Name of Insured: \_\_\_\_\_ Is insured a patient?  Yes  No

Insured's Birth Date: \_\_\_\_\_ ID# \_\_\_\_\_ Group# \_\_\_\_\_  
Insured's Address: \_\_\_\_\_  
Street City State Zip

Insured's Employer Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Street City State Zip

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 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 patients 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.

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 the 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. 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: \_\_\_\_\_