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): _____ 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 insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #:_____

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 insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #:_____

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: _____

_____

OUR POLICY OF PATIENT CARE AND PAYMENT

The goal of our practice is to ensure that you always receive the highest quality dental care available.

Payment is due at the time of service. If needed, payment arrangement needs to be made in advance. We accept cash, check and major credit cards. We also have payment plans available that allow you to start treatment today and spread payments over time, including interest free payment plans.

Payment Options: **1. Cash or Check** **2. Major Credit or Debit Cards**
3. Care Credit * **4. Dental Fee Plan**

APPLYING FOR CARE CREDIT OR DENTAL FEE PLAN ONLY TAKES A FEW MINUTES. THERE IS NO APPLICATION FEE

Please indicate below, the form of payment you choose to settle your account: Please Check One:

Cash or Check ☐ : Major Credit Card ☐ : Debit Card ☐ : Care Credit or Dental Fee Plan ☐ (Subject to Credit Approval)
If a credit application is declined, another form of payment listed above is required.

_____ **Date:** _____
Signature of Patient , Parent or Guardian