Date _____

Patient Information

Name _____ Home Phone _____
Social Security # _____ Cell Phone _____
Birth Date _____ Email Address _____
Which method do you prefer for appointment reminders? ❑ Email ❑ Cell Phone/Text ❑ Home Phone
May we email you our monthly electronic newsletter: ❑ Yes ❑ No

Home Address _____
City _____ State/Zip _____
Employed By _____ Work Phone/Ext _____
Address of Employment _____
Name of Spouse _____ Spouse Birth Date _____
Spouse's Social Security _____ Spouse Employed By _____
Who may we thank for referring you? _____
If other than patient please sign here _____
Emergency Contact Name & Phone Number _____

Payment Method

I hereby choose one of the following methods of payment for my dental care and the care of any immediate family members.

❑ I have no dental insurance.

_____ I elect to pay cash ___, check ___, or credit card at all visits as treatment progresses. On extensive treatment, financial arrangements can be established.

❑ I have dental insurance.

_____ I agree to pay any out of pocket expenses and deductible at the time of service.
_____ On extensive treatment, I elect to participate in financial arrangements coordinating insurance coverage and out-of-pocket expenses.
_____ I elect to coordinate insurance money as pre-authorized.

I HEREBY AGREE TO PAY ALL FINANCE CHARGES OF 12% ANNUALLY ON ANY BALANCES OVER 60 DAYS.

Insurance Information

I hereby authorize The Dental Team to bill my insurance company for treatment provided.
Your Dental Insurance Company _____ Tel # _____
Insurance Address _____
Group/or Employer _____ Group # _____ ID# _____
Spouse's Dental Insurance Company _____ Tel # _____
Insurance Address _____
Group/ or Employer _____ Group # _____ ID# _____

Payment Agreement

I HAVE READ AND UNDERSTAND THE FINANCIAL POLICY. I GUARANTEE PAYMENT OF ALL CHARGES INCURRED FOR THE ACCOUNT OF THE BELOW PATIENT. I AGREE TO PAY FINANCE CHARGES OF 12% ANNUALLY ON ANY BALANCE OVER 60 DAYS. I FURTHER AGREE TO REIMBURSE THE DENTAL TEAM THE FEES OF ANY COLLECTION AGENCY. THESE FEES MAY BE BASED ON A PERCENTAGE OF A MAXIMUM OF 33% OF THE DEBT, ALL COSTS, AND EXPENSES, INCLUDING REASONABLE ATTORNEY FEES THAT THE DENTAL TEAM INCUR IN SUCH COLLECTION EFFORTS.

_____ _____
Patient or Authorized Guardian Signature Date

Authorization to Release Information

I HEREBY AUTHORIZE THE DENTAL TEAM TO PROVIDE ANY INSURANCE COMPANY(S), CLAIM ADMINISTRATOR(S), AND CONSULTING HEALTH CARE PROFESSIONALS, INFORMATION CONCERNING HEALTH CARE, ADVICE, TREATMENT, OR SUPPLIES PROVIDED. THIS INFORMATION WILL BE USED EXCLUSIVELY FOR THE PURPOSE OF EVALUATING AND ADMINISTERING CLAIMS FOR BENEFITS.

I HEREBY AGREE TO PAY FINANCE CHARGES OF 12% ANNUALLY ON ANY BALANCE OVER 60 DAYS. I HEREBY AUTHORIZE THE DENTAL TEAM TO RUN A CREDIT REPORT IF NECESSARY.

_____ _____
Patient or Authorized Guardian Signature Date