Name: _____ SS# _____

Address: _____

City: _____ ZIP: _____

Mailing Address : _____
(if different) City Zip

Home Phone: _____ Patient Date of Birth: _____

Work Phone: _____ Cell: _____

E-mail: _____ Spouse: _____

Name of Insured/Parent: _____ SS# _____

Employer: _____

Address: _____

Insurance: _____

Address: _____

Policy # _____

Secondary Insurance Co. _____

Referred by _____

Dear Patient,

Please carefully read and sign below to acknowledge your understanding and agreement. Thank you for choosing us for your dental care. We are committed to providing you with the best care available. The following is a statement of our Financial Policy, which we would like you to read and sign prior to treatment so there are no misunderstandings.

Regarding Insurance: We bill insurance for you as a courtesy when you provide us with the needed information. It is not our responsibility to know what your insurance company will and will not cover. It is your responsibility to make sure we are a Participating Provider with your insurance company or if you must see their provider to receive benefits. There are so many different plans with each insurance company that we are unable to guarantee that we are on a specific plan. We accept all insurance except DentiCal.

If you would like a price estimate prior to services being rendered, please ask. We can also send a pre-authorization to the insurance company to see what they will pay on planed treatments. If there is a problem with insurance company payments you are responsible for all fees. We will provide you with the information so you can personally submit it to and seek reimbursement from your insurance company.

Usual And Customary Fees: Our practice is committed to providing the highest level of professional care and service we can. Our fees are based on many factors including the skill, care, judgment of our staff, quality of supplies and equipment, and our continuing professional dental education. Insurance companies may arbitrarily determine a geographic "usual and customary fee". Any insurance company determination of what is usual and customary will not impact the quality of care you receive, and you will be responsible for our entire professional fee. We accept all major credit cards, checks, and cash.

_____ _____

Signature of Patient or Responsible Party Date