

Patient Info.	Patient's Name _____ <small>First Middle Last</small>		
	Date of Birth _____		SSN _____
	Address _____		City _____ State _____
	Home Phone _____		Student _____ Yes _____ No _____ Zip _____
	Child Lives With _____		Relationship _____
*Whom May We Thank For Your Referral _____			
Resp. Party Info.	Responsible Party _____		Relationship _____
	Mailing Address _____		Phone #'s Home _____
	City _____ State _____		Zip _____ Cell _____
	Date of Birth _____		SSN _____
	Employer Name _____		Address _____
	Employer's Telephone # _____		Drivers Lic. # _____
Insur. Info	Name _____		Date of Birth _____
	SSN _____		Relationship _____
	Employer _____		How Long _____
	Dental Only (Not Medical)		
	Insurance Company Plan Name _____		Copy of Most Recent Dental Card Preferred
	Claims Address _____		
	Phone Number _____		

* **PAYMENT POLICY AND OPTIONS:** Payment for treatment is due at time it is provided. We offer several options to you in order to make the treatment we deliver affordable and acceptable to your budget.

1. We accept cash, personal checks and debit cards.
2. We also accept Visa and MasterCard for your convenience.
3. If you require an extended payment plan we offer qualifying parents a variety of options from which to choose. Please ask our business office staff for details.

DENTAL INSURANCE: As a courtesy we will gladly file your claims and accept assignment of dental insurance benefits provided you agree to the following:

- You must provide us with an insurance card and all the information necessary to verify your child's coverage and file your claim.
- Your Insurance policy is a contract between you, your employer and the insurance company. We are NOT a party to that contract. Our relationship is with you and not your insurance company.
- You are responsible for our fees and not what your insurance company allows or considers "usual, customary and reasonable" all of which vary from one company to another.
- Although we may estimate your insurance benefits, we are not responsible for their accuracy. Knowledge of benefits as well as benefit amounts, limitations, exclusions, waiting periods, etc. is entirely YOUR responsibility. Receiving our services indicates your acceptance of responsibility to pay regardless of our estimate.
- All charges not paid by your insurance company are your responsibility regardless of the reason for nonpayment. Not all services we provide are covered benefits. Benefits differ from one company to another. Fees for noncovered services, along with deductibles and copayments are due at the time of treatment.

Date _____ Signed _____
Parent/Guardian

Childs Name _____ Relationship _____
(Print)