Person Responsible for Payment

Name: _____
Last First Middle

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

E-mail Address: _____

How would you like us to confirm your appointments? (Circle) Email Home Work Cell

Marital Status (Circle): Single Married Separated Divorced Widowed

Social Security #: _____ Sex (Circle): Male Female Birth Date: _____

Relationship to Patient (Circle): Self Spouse Child Other _____

Emergency Contact: _____
Name Address Phone #

Insurance

Primary Dental Insurance: _____ Subscriber Name: _____

ID #: _____ Birthdate: _____ Group #: _____ Employer: _____

Dental Insurance Mailing Address: _____

Secondary Dental Insurance: _____ Subscriber Name: _____

ID #: _____ Birthdate: _____ Group #: _____ Employer: _____

Dental Insurance Mailing Address: _____

I authorize the release of any medical or other information necessary to process my claims as well as payment of dental benefits to Dr. Wadhwani or Dr. Smith for services rendered. This authorization shall remain valid until such time as I request otherwise. _____

Office Financial Policy

I understand that payment in full is expected at the time of service for all appointments. Payment can be made by cash, check, or major credit card. ***Our office is not a preferred provider for any insurance company***; however, we will be happy to submit claims to most dental insurance carriers. Please check with the receptionist to see if your plan is one of them. All other insurance claims (including medical and accident claims) are the responsibility of the patient. Accounts over 30 days will accrue a monthly service charge of 1%. Unresolved accounts over 60 days due will be sent to a collection agency.

Missed Appointment / Late Cancellations

Broken appointments represent a cost to us, to you and to the other patients who could have been seen in the time set aside for you. Cancellations are requested 48 hours prior to the appointment. We reserve the right to charge for missed or late cancelled appointments. Excessive abuse of scheduled appointments may result in discharge from the practice.

Please sign below to acknowledge that you have read and agree to the above policy.

Signature _____ Date _____