Responsible Party Information:

(This is the account guarantor and this person MUST sign below)

If PATIENT Initial here and skip this section _____

Name _____

Relationship to Patient _____

Address _____

City _____State_____Zip_____

Birth Date _____

Social Security # _____

Male _____ Female _____

Home Phone ( ) _____

Cell Phone ( ) _____

Employer _____

Employer Phone ( ) _____

Dental Insurance (Benefits) Information

Primary:

Name of Policy Holder _____

Relationship to Patient _____

Policy Holders Birth Date _____

SS# or ID # _____

Group or Policy # _____

Insurance Company Name _____

Ins Company Phone # _____

Secondary:

Name of Policy Holder _____

Relationship to Patient _____

Policy Holders Birth Date _____

Group or Policy # _____

Insurance Company Name _____

Ins Company Phone # _____

MEDICAID# _____

***Having Dentaquest Thru Medicaid DOES NOT guarantee any Payment. I Fully understand if they do not pay, I will owe. _____Intitial**

Payment Options:

***Cash, Check or Credit Card at time of service (Visa, MC, or Discover)**

*** Extended payment plan (Thru Care Credit or Lending Club) On approved Credit**

*** Auto Monthly Deduction from a Credit Card on File up on Maximum of 3 months (Interest of 20% may be applied)**

Financial Agreement:

THIS SECTION MUST BE SIGNED!!!

***** I understand payment is due at the time of service. If a I have dental insurance benefits, I agree to pay my estimated out-of-pocket expenses at the time of treatment!

* I understand all balances over 60 days are subject to a month billing charge of 1.25% plus a $10.00 statement fee.

* I agree to be responsible for all charges which remain unpaid by my insurance after 45 days.

* I understand and agree to Pay Any fees assessed that insurance does not pay. I understand that insurance is only a benefit and does not always pay what is expected. There may be Unforseen reasons, such as a service done previously at another office or waiting periods that we the provider are unaware of. I (the Patient) or (legal guardian) agree to pay any service that is NOT covered or PAID by an insurance company.

* I understand that I am legally responsible for charges that exceed what Insurane will allow or pay for: Maximums may apply, Deductibles may apply. Lab Charges for material that is not base metal may apply if insurance allows. Ex: Medicaid/Dentaquest only allows for base metal - you will have to pay for additional lab charges to upgrade to a different material. Any cosmetic treatment is your responsiblity - insurance only allows for broken down, decay, or traumatized teeth or gums.

I Understand that I will need to give a 24 hour notice to change any appointment or a **$50.00 charge will be applied per hour scheduled**. If I miss more than 3 appointments - Brothers Dental has the right to refuse treatment until appointments are prepaid for in advance or dismiss me from the practice.

I here by authorize and direct Brothers Dental, as assisted by other dentist and auxiliaries, to perform necessary dental treatment.
All Patients under the age of 18 must have a parent or legal guardian present for all scheduled appointments

_____ _____

Patient / Guardian Signature (Account Guarantor) Date

Patient NAME (PRINT) : _____