

Financial Responsibility

Individual (not insurance) responsible for this account _____

Address if different from patient _____ SS# _____

Employer Name _____ Address _____ Phone _____

City, State & Zip _____ Current Position _____ How long _____

Spouse Name _____ Spouse Employer _____

Phone _____ SS# _____ Current Position _____

Address _____ City, State & Zip _____

Insurance Information

All information must be completed or insurance cannot be filed

Is the patient a full time college student? (Yes / no) If yes, where _____

Primary Dental Ins. Co. _____ Phone _____ Group# _____

Insurance Address _____ Subscriber Employer _____

Subscriber's Name _____ SS or ID# _____ Birthday _____

Secondary Dental Ins. Co. _____ Phone _____ Group# _____

Insurance Address _____ Subscriber Employer _____

Subscriber's Name _____ SS or ID# _____ Birthday _____

Medical Ins. Co. _____ Phone _____ Group# _____

Insurance Address _____ Subscriber Employer _____

Subscriber's Name _____ SS or ID# _____ Birthday _____

THE PATIENT HEREBY AUTHORIZES THE HEALTH CARE PROVIDER, IT'S AGENTS OR ASSIGNERS TO DISCUSS THE PATIENTS ACCOUNT WITH THE PATIENT'S INSURANCE PROVIDER OR ANY OTHER THIRD PARTY, IN ORDER TO AFFECT PAYMENT OF UNPAID BALANCES. FURTHER, IT IS AGREED THAT SHOULD MY ACCOUNT BECOME DELINQUENT, I WILL BE RESPONSIBLE FOR ANY CHARGES THAT ARE INCURRED IN THE COLLECTION OF MY BILL. THIS INCLUDES, BUT IS NOT LIMITED TO: LATE FEES, COLLECTION AGENCY FEES, COURT COSTS, ATTORNEY FEES, ETC.

I certify that I have had the opportunity to read and understand the financial policy for this office, agree to abide by said policy for services rendered, and to assign dental insurance benefits to Central Arkansas Oral & Maxillofacial Surgery Center, Dr. Steven Molpus and Dr, William Alfonso.

Patient's Name

Patient, Parent or Guardian's Signature

Date