

DEPENDANT INFORMATION

PATIENT'S NAME _____ BIRTHDATE _____ RES. PHONE _____

RESIDENCE ADDRESS _____ CITY _____ STATE _____ ZIP _____

IS PATIENT A FULL TIME STUDENT? _____ NAME OF SCHOOL _____

FATHER/GUARDIAN NAME _____ DRIVER'S LICENSE NUMBER _____ EXP. _____

SSN _____ DATE OF BIRTH _____

EMPLOYED BY _____ POSITION _____ BUS. PHONE _____

BUSINESS ADDRESS _____ CITY _____ STATE _____ ZIP _____

BILLING ADDRESS _____ CITY _____ STATE _____ ZIP _____

CELL PHONE / PAGER _____

MOTHER/GUARDIAN NAME _____ DRIVER'S LICENSE NUMBER _____ EXP. _____

SSN _____ DATE OF BIRTH _____

EMPLOYED BY _____ POSITION _____ BUS. PHONE _____

BUSINESS ADDRESS _____ CITY _____ STATE _____ ZIP _____

BILLING ADDRESS _____ CITY _____ STATE _____ ZIP _____

CELL PHONE / PAGER _____

FATHER/GUARDIAN HOME PHONE _____ MOTHER /GUARDIAN HOME PHONE _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

OFFICE FINANCIAL POLICY

WE MAINTAIN A HIGH STANDARD, FEE FOR SERVICE, GENERAL PRACTICE. GUIDELINES HAVE BEEN ESTABLISHED TO KEEP TO A MINIMUM THE LABOR INTENSIVE MANAGEMENT OF PATIENT ACCOUNTS. WE REQUIRE PAYMENT FOR ALL DENTAL CARE ON THE DAY OF SERVICE.

FOR PATIENTS WHO CARRY INSURANCE, WE BILL THE PRIMARY INSURANCE, AS A COURTESY.

FOR ALL SERVICES RENDERED. WE EXPECT THE PATIENT'S UNINSURED COPAYMENT TO BE PAID IN FULL ON THE DAY OF SERVICE.

PAYMENT MAY BE MADE BY CASH OR PERSONAL CHECK AND WE ACCEPT ALL CREDIT CARDS.

TERMS AND CONDITIONS

THE PRACTICE DEPENDS UPON REIMBURSEMENT FROM OUR PATIENTS AND FINANCIAL RESPONSIBILITY MUST BE DETERMINED BEFORE TREATMENT. FAILED OR SHORT-NOTICE CANCELLATIONS ARE DISRUPTIVE TO OTHER PATIENTS NEEDING TO BE SEEN. PLEASE HELP US MINIMIZE THEM. A NON-REFUNDABLE FEE WILL BE INSTITUTED FOR REPEATED CANCELLATIONS.

ALL EMERGENCY, OR DENTAL SERVICES PERFORMED WITHOUT PRIOR FINANCIAL ARRANGEMENTS, MUST BE PAID IN FULL AT THE TIME TREATMENT IS RENDERED.

PATIENTS WHO CARRY DENTAL INSURANCE UNDERSTAND THAT ALL DENTAL TREATMENT RENDERED IS CHARGED DIRECTLY TO THE PATIENT AND THE PATIENT IS PERSONALLY RESPONSIBLE FOR PAYMENT, REGARDLESS OF INSURANCE. I FURTHER UNDERSTAND THAT IF MY ACCOUNT IS NOT PAID IN FULL WITHIN 60 DAYS, A FINANCE CHARGE WILL BE ASSESSED TO THE UNPAID BALANCE IN THE AMOUNT OF 1 1/2% PER MONTH (18% PER ANNUM).

SIGNED _____ DATE _____

DAVID TASSEY, D.D.S.
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