

GENERAL INFORMATION FINANCIAL WAIVER

TODAY'S DATE _____

Last Name: _____

First Name: _____ I prefer to be called: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Pager/Other: _____ E-Mail: _____

Work Phone: _____ Ext: _____ DL#: _____

Birthday: _____ M _____ F _____ Social Security #: _____

Person Responsible for the account _____

Employer: _____ Address: _____

How Long There? _____ Occupation: _____

How did you hear about our office? _____ Who Referred You? _____

Other family members seen by us? _____

Previous Dentist: _____ Phone Number: _____ Last Visit: _____

IN THE EVENT OF AN EMERGENCY, WHO CAN WE CONTACT?

Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____

FINANCIAL WAIVER

Office Policy: We request payment in full at the time of visit. We will accept assignment for insurance benefits for those insurance companies with which we are a participating dentist: Delta Dental, Anthem/Blue Cross/Blue Shield, and Prudential. Any balance not paid by insurance is YOUR responsibility. Financial Arrangements for balances over \$500.00 will be made at the discretion of the Office Manager and Doctor. We reserve the right to check credit record and history. Accounts delinquent over 60 days will be subject to a finance charge. After 90 days your account may be placed in the hands of a collection agency or lawyer. Accounts delinquent over 90 days may be reported to TRW Credit Services.

I understand and accept the above terms _____ Date: _____

Your Signature