Employment information

The following is for: __ the patient **or** __the person responsible for payment:

Employer Name: ___________________________ Occupation: _____________________________

Address: _____________________ City_______ State_____ Zip ______ Phone number_____________

Dental Insurance Information

Primary

Name of insured: ______________________ Is insured a patient: **Yes No**
Insured's Birth date___/___/_____ ID# _________________ Group# _______________
Insured's Address: _________________ City_________ State________ Zip______
Insured's Employers Name: ________________ Address: ________________ City_______ State_____ Zip_____
Patient's relationship to insured: __ Self, __ Spouse, __Child, __Other; _____
Insurance Plan Name: _____________________

Secondary

Name of insured: ______________________ Is insured a patient: **Yes No**
Insured's Birth date___/___/_____ ID# _________________ Group# _______________
Insured's Address: _________________ City_________ State________ Zip______
Insured's Employers Name: ________________ Address: ________________ City_______ State_____ Zip_____
Patient's relationship to insured: __ Self, __ Spouse, __Child, __Other; _____
Insurance Plan Name: _____________________

Pharmacy Information

Name of Pharmacy: ______________
Address: _______________________ City_________ State________ Zip______ Phone number: _____________

Consent for Service

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part patient must be determined before treatment.
I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.
In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services t said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.
I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this from.
I have read the above conditions of treatment and payment and agree to their consents.

- **Signature of patient, parent, or guardian** _______________________ Date ___/___/_____
- **Signature of guarantor payment/responsible party** ___________________ Date ___/___/______