MASSIE DENTAL

Date _____

Patient Information

Name(Last, First, MI) : _____ Male ☐ Female ☐

Street Address : _____ Single ☐ Married ☐ Child ☐

City _____ State ____ Zip _____ Widowed ☐ Divorced ☐

E-mail Address : _____ Would you like e-mails for appts: Yes / No

Phone: Home _____ Cell _____ Would you like texts for appts: Yes / No

Birth Date: _____ Social Security Number: _____

If covered by Parent/Guardian Insurance please fill out next section – otherwise skip to employer info

Parent/Guardian

Name (Last, First, MI) : _____ Male ☐ Female ☐

Street Address : _____ Birth Date _____

City _____ State ____ Zip _____ Social Security Number _____

Employer Info

Name _____ Phone _____ Ext _____ May we call work Yes / No

Street Address: _____City: _____ State:_____ Zip:_____

Whom may we thank for referring you to our practice ? _____

☐ Family ☐ Friend ☐ Another Patient ☐ Phone Book ☐ Internet

INSURANCE – If no coverage skip to next section

PRIMARY COVERAGE

Name of Insured: _____ Social Security Number : _____

Birth Date: _____ Male ☐ Female ☐ ID # _____ Group # _____

Employer : _____ Phone : _ _____ Address: _____

City : _____ State: ____ Zip: _____

Plan Name : _____ Insurance Phone Number : _____

Insurance Address : _____ City: _____ State: ____ Zip _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

SECONDARY COVERAGE

Name of Insured: _____ Social Security Number : _____

Birth Date: _____ Male ☐ Female ☐ ID # _____ Group # _____

Employer : _____ Phone : _ _____ Address: _____

City : _____ State: ____ Zip: _____

Plan Name : _____ Insurance Phone Number : _____

Insurance Address : _____ City: _____ State: ____ Zip _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

MEDICAL COVERAGE – ***Only if due to an accident or Dental Sleep Appliance***

Name of Insured: _____ Social Security Number : _____

Birth Date: _____ ID # _____ Group # _____

Employer : _____ Phone : _ _____ Address: _____

City : _____ State: ____ Zip: _____

Plan Name : _____ _____ Insurance Phone Number : _____

Insurance Address : _____ City: _____ State: ____ Zip _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Consent for Services / Assignment of Benefits

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 part of each patient must be determined before treatment.

All emergency dental services, or any dental services are performed without previous financial arrangements, must be paid in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged on directly to the patient and that he/she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by the insurance company.

A service charge of 1 ½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previous financial arrangements are satisfied.

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 patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the stated value of said services to Massie Dental, at the time of said services are rendered or within five(5) days of billing if credit shall be extended. I further agree that the stated value of said services shall be billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term if condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant permission to Massie Dental to telephone me at home or work to discuss matters related to this form.

X_____ Date _____ Relationship to Patient _____

Signature of patient, parent or guardian

X_____ Date _____ Relationship to Patient _____

Signature of guarantor of for payment and assignment of benefits on insurance