



General Information

Financial Waiver

Today's Date: _____

Last Name: _____

First Name: _____ I prefer to be called: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ E-Mail: _____

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

Person Responsible for the Account: _____ Driver lic. # _____

Employer: _____ Address: _____

How did you hear about our office? _____

Previous dentist: _____ Last Visit: _____ Phone Number or Town: _____

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, and Anthem Blue Cross/Blue Shield. Any balance not paid by insurance is **YOUR** responsibility. Financial Arrangements for balances over \$500 will be made at the discretion of the office Manager and/or 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. Lack of acceptance of these terms indicates that payment will be due as services are rendered.

I understand and accept the above terms: _____ Date: _____