PATIENT WITH INSURANCE

ATTENDING DR. _____ CHART NUMBER _____

PATIENT INFORMATION

PATIENT	STREET ADDRESS		
CITY & STATE	ZIP CODE	HOME	CELL
WHO REFERRED YOU TO THIS OFFICE?	GENERAL DENTIST	HOW LONG HAVE YOU BEEN A PATIENT OF GENERAL DDS?	
SOCIAL SECURITY #	DATE OF BIRTH	GENDER: FEMALE ☐ MALE ☐	
EMPLOYER	OCCUPATION	WORK PHONE	

PRIMARY DENTAL INSURANCE – SUBSCRIBER / CARDHOLDER INFORMATION

SUBSCRIBER'S NAME	SOCIAL SECURITY #	INSURANCE I.D. #
STREET ADDRESS/ CITY / STATE / ZIP – (IF DIFFERENT THAN ABOVE)		CELL PHONE
SUBSCRIBER'S DATE OF BIRTH	IS THE PATIENT THE: ☐ SUBSCRIBER ☐ SPOUSE ☐ DEPENDENT	SUBSCRIBER'S EMPLOYER
OCCUPATION		WORK PHONE
INSURANCE COMPANY	GROUP #	% COVERAGE

SECONDARY DENTAL INSURANCE – SUBSCRIBER / CARDHOLDER INFORMATION

SUBSCRIBER'S NAME	SOCIAL SECURITY #	INSURANCE I.D. #
STREET ADDRESS/ CITY / STATE / ZIP – (IF DIFFERENT THAN ABOVE)		CELL PHONE
SUBSCRIBER'S DATE OF BIRTH	IS THE PATIENT THE: ☐ SUBSCRIBER ☐ SPOUSE ☐ DEPENDENT	SUBSCRIBER'S EMPLOYER
OCCUPATION		WORK PHONE
INSURANCE COMPANY	GROUP #	% COVERAGE

WE WILL SUBMIT YOUR INSURANCE FORMS FOR YOU. HOWEVER, WE DO NOT KNOW IF THEY WILL PAY ANY OF THE CLAIM. IF THE INSURANCE COMPANY DOES NOT PAY WHAT IS ANTICIPATED, THE PATIENT / GUARDIAN REMAINS RESPONSIBLE FOR THE BALANCE.

Because of the nature of referral work, we must respectfully request that all patient balances be paid upon completion. If unable to do so, please advise us now. Time payments are available only through MasterCard, Visa, Discover Card, Amex or Care Credit.

Charges not paid within 30 days will have a service charge of 0.58% per month (Annual rate of 7%) added to the past due balance on each monthly statement thereafter.

In the event of non-payment for our services, I understand that collection agency fees, including attorney fees, if applicable, will be applied to the outstanding balance.

Our usual and customary fee schedule on file with dental insurance companies, State of Michigan:

Consultation and Exam	125.00	3D Imaging	150.00
Anterior Root Canal	1050.00	Surgical Biopsy Removal	375.00
Bicuspid Root Canal	1245.00	Incision & Drainage	125.00
Molar Root Canal	1410.00	First Film	35.00
Retreat Anterior Root Canal	1295.00	Each Additional Film	30.00
Retreat Bicuspid Root Canal	1495.00	Pulp Testing	55.00
Retreat Molar Root Canal	1660.00	Nitrous Oxide	100.00
Surgery (including retrograde fill)	1710.00	Emergency Treatment Only	300.00

I, the undersigned, being the patient, parent or guardian state the above information is true to the best of my knowledge and understand that I am ultimately responsible for any charges incurred. I authorize release of any information relating to this claim. I hereby authorize payment directly to the attending dentist of the group insurance benefits otherwise payable to me.

SIGNATURE _____ DATE _____