ART CITY DENTAL

ROBERT N. PERKINS D.M.D.

Date _____

Patient's Name _____ **Birth Date** _____ **Age** _____

Address _____ **City** _____ **Zip Code** _____

Sex: M ○ **F** ○ **Patient's Social Security #** _____ **Marital Status: M** ○ **S** ○ **W** ○ **D** ○

Home Phone # _____ **Business Phone #** _____

Patient's Occupation_____ **Number of Dependents**_____

Is patient a full time student? Y ○ **N** ○ **Name of School** _____

Spouse's Name _____ **Spouse's Soc. Sec. #** _____ **Occupation** _____

Spouse's Employer _____ **Bus. Phone#** _____

Person to contact in case of emergency _____

Address _____ **Phone #** _____ **Relationship** _____

Referred by _____

Family ○ **Friend** ○ **Phone Directory** ○

PERSON RESPONSIBLE FOR PAYMENT OF THIS ACCOUNT

Name of responsible party _____ **Relationship** _____

Residence Address _____ **City** _____ **Zip Code** _____

Home Phone # _____ **Social Security #** _____

Employer _____ **No. years employed** _____

Employer's Address _____ **City** _____ **Zip Code** _____

Union Local No. _____ **Business Phone #** _____

Will dental insurance be involved? Yes ○ **No** ○ **If yes, complete next section.**

PATIENT INSURANCE INFORMATION (Use your identification card)

Subscriber's Name _____ **Subscriber's Soc. Security #** _____

Your relationship to subscriber Self ○ **Spouse** ○ **Child** ○ **Other** ○ _____

Name of Insurance Company _____ **Group Number** _____

Address where claim should be sent _____

Effective Date _____

Insurance Company Phone # _____ **Contract #** _____ **Plan #** _____

Subscriber's Employer _____ **Employer Phone #** _____

Union Local _____ **Subscriber's Birth Date** _____

Is Patient covered under more than one Dental Plan? Yes ○ **No** ○ **If yes, complete next section.**

SECONDARY INSURANCE

Subscriber's Name _____ **Birth Date** _____

Social Security # _____ **Employer** _____

Insurance Co. _____ **Group #** _____

Address where claim should be sent _____

Subscriber relationship to patient Self ○ **Spouse** ○ **Child** ○ **Other** ○ _____

ART CITY DENTAL

ROBERT N. PERKINS D.M.D.

OFFICE FINANCIAL POLICIES AND FEDERAL TRUTH-IN-LENDING STATEMENT

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from our patients for the costs incurred in their care to remain viable and financial responsibility on the part of each patient must be determined before treatment.

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

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

A service charge of 1.5% per month (18% per annum) on the unpaid balance will be assessed on all accounts exceeding sixty days from the date of service unless previously written 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 the patient examination.

In consideration for the professional services rendered to me, or at my request for my minor child or ward by the dentist, I agree to pay, therefore, the reasonable value of said services to said dentist 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 that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition, and I further agree to pay all costs and reasonable attorney fees if a suit is instituted hereunder to collect monies owed by me. I authorize the release of financially identifiable information concerning my account including charges billed, payments made, and interest charges assessed, etc. to the dentist's collection agency or collection attorney should collection procedures as described become necessary.

If you are unable to keep an appointment, please call at least 24 hours prior to that appointment. A late cancellation fee of $68 will be charged for appointments canceled within 24 hours.

I grant my permission to you or your assignee to telephone me at home or at my workplace to discuss matters related to this form.

This agreement supersedes all prior agreements signed, including any and all mediation or mediation/arbitration agreements. I acknowledge that any prior mediation or mediation/arbitration agreements signed previously related to financial arrangements or quality of care are null and void.

I authorize the dentist or his designees to release financially identifiable information and treatment descriptions and information, either electronically, by facsimile or paper form to my insurance carrier or any related entities that require such information to be submitted.

I certify that I have answered all questions on both sides of this form accurately and to the best of my knowledge. I hereby agree to abide by the conditions outlined herein.

_____	_____	_____
Signature of Patient, parent or guardian	Date	Witness