

Jared T. Bowyer D.D.S.

DENTAL ASSISTANCE (INSURANCE) INFORMATION

Who May We Thank For Referring You: _____

Patient's Name: _____ Married Y/N Spouse Name _____

Patient's Address: _____ Hm Phone: _____ Wk Phone: _____

_____ Email: _____ Cell Phone: _____

Birthdate: _____ SS# _____ Best Way To Contact: Phone Email Text
(Circle One)

Responsible Party: _____

Responsible Party Address: _____ Hm Phone: _____ Wk Phone: _____

_____ Social Security #: _____

Primary Subscriber (employee) Name: _____

Social Security #: _____ Birthdate: _____

Insurance Company Name: _____ Address: _____

Group or Policy #: _____

Employer: _____ Phone: _____

Do you have secondary insurance? Yes No (if yes, see back of form)

Regarding Insurance And Consent for Services

I hereby authorize doctor or designated staff to take x-rays, study models, photographs and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis.

Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

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

I understand that I am responsible for all fees regardless of insurance coverage and that as treatment progresses fees may be adjusted, but that I will be informed of these adjustments and how they will affect my payment. If required, I also understand a check of my credit history may be made.

A service charge of 1% per month (12% per annum) on the unpaid balance will be charged on all accounts exceeding 90 days, unless previously written financial arrangements are satisfied.

I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent or guardian Date: _____ Relationship to Patient: _____

Signature of guarantor of payment/responsible party Date: _____ Relationship to Patient: _____