





## Insurance Information

### Primary

Name of Insured: \_\_\_\_\_ Is the insured a patient?  Yes  No

Insured's Birth Date: \_\_\_\_\_ ID#: \_\_\_\_\_ Group #: \_\_\_\_\_

Insured's Address: \_\_\_\_\_  
Street City State Zip Code

Insured's Employer Name: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip Code

Patient's relationship to insured  Self  Spouse  Child  Other \_\_\_\_\_

Insurance Plan Name and Address \_\_\_\_\_

### Secondary

Name of Insured: \_\_\_\_\_ Is the insured a patient?  Yes  No Insured's

Birth Date: \_\_\_\_\_ ID#: \_\_\_\_\_ Group #: \_\_\_\_\_

Insured's Address: \_\_\_\_\_  
Street City State Zip Code

Insured's Employer Name: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip Code

Patients relationship to insured  Self  Spouse  Child  Other \_\_\_\_\_

Insurance Plan Name and Address \_\_\_\_\_

### Assignment and Release

I certify that I, and my dependent(s), have insurance coverage with \_\_\_\_\_ and assign directly to Judy Anderson, DDS all insurance benefits if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance, I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

\_\_\_\_\_/\_\_\_\_\_  
Signature of Patient, Parent, Guardian or Personal Representative Please print name of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Date Relationship to Patient

## Consent for Services

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 debts incurred in their care and financial responsibilities 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 performed.

Patients who carry dental insurance understand that all dental services furnished 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 patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patients account. However this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, 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, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, 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 suit be instituted thereunder.

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

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: \_\_\_\_\_

## Financial Policy

**Dr. Anderson provides the highest quality dental care available. Our focus is on long term success and health in a gentle, caring environment.**

**Some services we provide:**

- \* All types of crowns & bridges**
- \* Mercury Free Dentistry**
- \* White Fillings**
- \* Veneers**
- \* Cosmetic Dentistry**
- \* Non-surgical Periodontal Therapy**
- \* Extractions**
- \* Partial**
- \* Dentures**
- \* Teeth Whitening**
- \* Implants**

I understand and acknowledge that I am financially responsible for services provided for myself (or minor child), regardless of insurance coverage.

\_\_\_\_\_  
Signature of Patient, Parent, Guardian

\_\_\_\_\_  
Date

I understand if appointment is not cancelled 24 hours in advance a fee will be charged to me.

\_\_\_\_\_  
Signature of Patient, Parent, Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Please print name of Patient, Parent, Guardian or Personal Representative