Bridgetower Dental

Namo:					Duofou to	ho sallad.		
Name: First			II Last	Prefer to be called:				
DOB: _		Age:	SS#:		Marital Sta	tus:	[]M[]F	
						Cell Phone:		
Employer:O				Work Phone:				
Spouse or Parent's name:								
					Relationship to Patient:			
					Phone:			
INSUI PRIMA					DOR:	SS#:		
r Karia	к							
						ID#:		
	Ins. Co. Address:							
SECON	DARY: Employee's name:			DOB:	3: SS#:			
		Employer:		Pho	one:	ID#:		
		Group#:	Insurance Co	:				
		Ins. Co. Address:		Ins. Co Phone:				
The info	rmation		s correct to the be	est of my knowled	ge. I ackno	wledge the following	:	
1.	I have	been advised of the H	IIPAA Notice of Pr	ivacy Practices pro	ovided by th	nis office.		
	I will hereby advise the office of any and all changes to my medical history at each appointment. I hereby authorize direct payment from my Insurance Company to BRIDGETOWER DENTAL and further authorize							
	release	of any and all inform	ation requested b	y said insurance of	company for	processing my claims	S.	
 Insurance claims are filed as a courtesy on the part of the dental office; if I feel that the innot paid correctly, it is my responsibility to contact them. The dental office will be 						I feel that the insura	nce company ha	
	paperwork necessary to help me settle any disputes with my insurance company.							
5.	5. I am financially responsible for all charges, regardless of my insurance coverage. I also real						lize that it is m	
-	responsibility to be familiar with my insurance policy and to immediately notify the office of any changes therein. Payment is due AT TIME OF SERVICE; if I have insurance, any and all copayments and/or deductibles are due a							
0.	time of	service. I can pay by	SERVICE; IT I have	dit card or CAREC	and all cop	ayments and/or dedu	ctibles are due a	
7.	If I refu	ise to provide my soc				h credit card or cash,	regardless of m	
		ce status. ordance with the Fed	deral Truth-In-Ler	nding Act: I realiz	ze that any	balance older than	60 days may b	

Responsible Party Signature Date:

subject to a billing charge of \$5.00 per month or finance charges of 21% APR, whichever is greater.

 If I am unable to keep a scheduled appointment, I will give the office <u>24 HOUR NOTICE</u>. All appointments are confirmed by E-mail correspondence, text, and or phone whenever possible and it is my responsibility to inform the office of any and all current phone numbers. A \$50.00 FEE WILL BE CHARGED FOR MISSED APPOINTMENTS.