Dental Group at Reston Station

Patient Information

☐ Male ☐ Female

Patient Name: _____ Date of Birth: _____
Last First MI

☐ Married ☐ Single ☐ Child ☐ Other _____ Social Security #: _____

Phone (Home): _____ (Work): _____ Ext: _____ (Cell): _____

E-Mail Address: _____ May we contact you by: Phone ☐ Text ☐ E-mail ☐

Address: _____
Street Apt # City State Zip Code

Patient Employer Name: _____ Occupation: _____

Employer Address: _____
Street City State Zip Code

The following is for: ☐ the patient's spouse and/or ☐ the person responsible for payment

☐ Male ☐ Female

Name: _____ Date of Birth: _____
Last First MI

☐ Married ☐ Single ☐ Child ☐ Other _____ Social Security #: _____

Phone (Home): _____ (Work): _____ Ext: _____ (Cell): _____

Address: _____
Street Apt # City State Zip Code

Employer Name: _____ Occupation: _____

Employer Address: _____
Street City State Zip Code

Whom may we thank for referring you to our practice? _____

Insurance Information

Primary

Name of Policyholder: _____ Date of Birth: _____
Last First MI

Policyholder's Home Address: _____ Phone (Home): _____
Street City State Zip Code

Policyholder's Employer Name: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Insurance Plan Name: _____ Policy ID #: _____ Plan Group #: _____

Mailing Address to Submit Claims: _____
Street City State Zip Code

Assignment of Benefits to Provider: _____
(Signed) Employee/Subscriber

Secondary

Name of Policyholder: _____ Date of Birth: _____
Last First MI

Policyholder's Home Address: _____ Phone (Home): _____
Street City State Zip Code

Policyholder's Employer Name: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Insurance Plan Name: _____ Policy ID #: _____ Plan Group #: _____

Mailing Address to Submit Claims: _____
Street City State Zip Code

Assignment of Benefits to Provider: _____
(Signed) Employee/Subscriber

CONSENT FOR SERVICES and FINANCIAL AGREEMENT

I, the undersigned, hereby authorize the Dental Group at Reston Station to take x-rays, study models, photographs or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my condition. I also authorize the Dental Group at Reston Station to perform any and all forms of treatment, medication and therapy that may be indicated in connection with treatment. I also understand that the use of anesthetic agents embodies a certain risk.

Insurance

Insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. Some have annual caps or multiple levels of coverage. I understand that the payment of my bill is my legal obligation. All filings of insurance papers and confirmation of insurance payments to be made by my insurance carrier are my responsibility, as is determining providers covered by my current insurance. Any assistance in this matter granted by the above doctor and/or staff is given strictly as a courtesy and implies no responsibility on their part for eligibility, filing, follow-through, or confirmation. Notification of change of insurance carrier or level of coverage (e.g. PPO) is my responsibility, as is any change of address.

Delinquent Accounts

IN THE EVENT THAT THIS ACCOUNT SHOULD BECOME DELINQUENT AND IS THEREFORE PLACED IN THE HANDS OF AN ATTORNEY FOR COLLECTION, I AGREE TO PAY ATTORNEY FEES OF 33 AND 1/3% OF THE UNPAID BALANCE OWING, PLUS ALL COURT COSTS, AND INTEREST. INTEREST IS CHARGED AT A RATE OF 1.5% PER MONTH (18% APR), BEGINNING 60 DAYS AFTER THE BALANCE HAVE BECOME DUE OR EXPENSES HAVE BEEN INCURRED. I FURTHER AGREE TO PAY A RETURNED CHECK CHARGE PER EACH RETURNED CHECK AND/OR A BROKEN APPOINTMENT FEE WITHOUT A 48 HOURS ADVANCED NOTICE. ANY PROFESSIONAL/COURTESY DISCOUNT IS CONTINGENT UPON EXECUTION OF THE PAYMENT TERM OUTLINED ABOVE AND MAY BE REVERSED AT THE DISCRETION OF THE PRACTICE IF THE ACCOUNT GOES INTO DEFAULT.

This agreement is reaffirmed each time services are received by me or any person on my account, including, but not limited to, any child, stepchild, or parents within my family, who receive services from any provider within the above-named practice.

_____ _____

Signature Printed Name

_____

Date