



Home Phone: Relationship:  
Work Phone: Home Phone:

#### 4. Dental Insurance Information

##### Primary Insurance

Name of Insured:  
Relationship to Patient:  
Insured's Birthdate:  
SS#:  
Employer:  
Date Employed:  
Occupation:  
Insurance Company:  
Group#:  
Employee/Cert. #:  
Ins. Co. Address :  
Deductible:  
Amount Already Used:  
Max Annual Benefit:

##### Additional Insurance

Name of Insured:  
Relationship to Patient:  
Insured's Birthdate:  
SS#:  
Employer:  
Date Employed:  
Occupation:  
Insurance Company:  
Group#:  
Employee/Cert. #:  
Ins. Co. Address:  
Deductible:  
Amount Already Used :  
Max Annual Benefit:

#### 5. Authorization and Release

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or other health practitioners.

I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actual bill services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X \_\_\_\_\_ Date:  
Signature of patient or parent if minor - (Sign copy at office)

#### 6. Financial Arrangements

For your convenience, we offer the following methods of payment. Please check the option you prefer. Full Payment is expected at each appointment.

Cash

Personal Check

Credit Card    Visa    MC

I wish to discuss the dental office's policy

### **Late Charges**

If I do not pay the entire new balance within 25 days of the monthly billing date, a late charge of 1.5% on the balance then unpaid and owed will be assessed each month (if allowed by law). I realize that failure to keep this account current may result in you being unable to provide additional dental services except for dental emergencies or where there is prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.

Thank you for filling out this form completely. The information you have provided will help us serve your dental healthcare needs more effectively and efficiently. If you have any questions at anytime, please ask - we are always happy to help.

**Dr. James Michaels DDS**