INSURANCE INFORMATION

PRIMARY

Name of Insured: _____ *Is insured a patient?* _____ *YES* _____ *NO*

Insured's Birth Date: _____ - _____ - _____ *ID#:* _____ *Group#:* _____

Insured's Address: _____

Insured's Employer's Name: _____ *Phone:* _____ - _____ - _____

Address: _____

Patient's Relationship to Insured: _____ *Self* _____ *Spouse* _____ *Child* _____ *Other*

Insurance Plan Name and Address: _____

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SECONDARY

Name of Insured: _____ *Is insured a patient?* _____ *YES* _____ *NO*

Insured's Birth Date: _____ - _____ - _____ *ID#:* _____ *Group#:* _____

Insured's Address: _____

Insured's Employer's Name: _____ *Phone:* _____ - _____ - _____

Address: _____

Patient's Relationship to Insured: _____ *Self* _____ *Spouse* _____ *Child* _____ *Other*

Insurance Plan Name and Address: _____

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Consent of Services

I authorize Dr. Richard Argant to perform dental treatment as he deems necessary at the time of service. 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 the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. All emergency dental services performed without previous financial arrangements, must be paid for in cash at the time services are rendered. Patients who carry dental insurance understand that all dental services furnished are changed 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 patient's 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 assignees, 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, or by me, in writing, with 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 1 further agree to pay all collection fees incurred if my account is referred to a collection agency and reasonable attorney fees if suit be instituted hereunder. 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 CONSENT.

Signature of Patient, Parent, or Guardian: _____ *Date:* _____

Signature of Guarantor of payment/responsible party: _____ *Date:* _____