WELCOME

Dr. John D. Stevens, DDS *Dr.Robert S. Landman,DMD*

Thank you for selelecting our Dental Healthcare Team! We will strive to provide you with the best possible dental care. To help us meet all your dental needs, Please fill out this form completely in ink and be sure to sign it. If you have any questions or need assistance, Please ask us - We will be happy to help.

RESPONSIBLE PARTY

Who is responsible for this account? In divided households, the person bringing in dependent children shall be responsible for payment of bills. Should a household become divided during course of treatment, the member who signs this form remains the responsible party for themselves and dependents regardless of any language to the contary.

NAME _____

ADDRESS _____

CITY, STATE, ZIP _____

BILLING ADRESS IF DIFFERENT FROM ABOVE:

_____

HOME PHONE _____ CELL PHONE _____

WORK PHONE _____ EXT.# _____

WHERE CAN WE REACH YOU DURING THE HOURS OF 9AM-6PM?

_____ OR _____

EMPLOYER _____

EMPLOYER ADDRESS _____

OCCUPATION _____

___MALE ___FEMALE

___SINGLE ___MARRIED ___SEPARATED ___DIVORCED ___WIDOWED

BIRTHDATE _ _-_ _-_ _ _ _ SOCIAL SECURITY #_ _ _-_ _-_ _ _ _

PLEASE NAME THOSE INDIVIDUALS TO BE BILLED TO THIS ACCOUNT

NAME _____ RELATIONSHIP _____

NAME _____ RELATIONSHIP _____

NAME _____ RELATIONSHIP _____

NAME _____ RELATIONSHIP _____

NAME _____ RELATIONSHIP _____

PLEASE COMPLETE OTHER SIDE & SIGN.

DENTAL INSURANCE INFORMATION

In order for us to submit claims to your insurance company on your behalf, this information must be completed in full. IF YOU DO NOT HAVE ALL OF THIS INFORMATION YOU WILL BE RESPONSIBLE FOR YOUR BILL AT TIME OF SERVICE.

PRIMARY INSURANCE

NAME OF INSURED _____
DATE OF BIRTH __-__-____
SOC. SEC. ___-__-____
EMPLOYER _____
ADDRESS _____
_____
PHONE # _____
OCCUPATION _____
DATE EMPLOYED _____

INSURANCE CO. _____
ADDRESS _____
_____
PHONE # _____
GROUP#_____EMP/CERT#_____
EFFECTIVE DATE __-__-____
ALSO PRIMARY FOR
__SPOUSE __CHILDREN

ADDITIONAL INSURANCE

NAME OF INSURED _____
DATE OF BIRTH __-__-____
SOC. SEC. ___-__-____
EMPLOYER _____
ADDRESS _____
_____
PHONE # _____
OCCUPATION _____
DATE EMPLOYED _____

INSURANCE CO. _____
ADDRESS _____
_____
PHONE # _____
GROUP#_____EMP/CERT#_____
EFFECTIVE DATE __-__-____ PRIMARY FOR CHILDREN __YES __NO

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 dependents 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 for services. I agree to be responsible for payment for all services rendered on my behalf or my dependents.

X_____ Date_____

Signature of patient or responsible party if minor.

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 assed each month. I relize that failure to keep this account current may result in you being unable to provide additional dental services except for dental emergencies or where prepayment will be required for additional services. In case of default on payment for this account, I agree to pay collection cost and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding balances.

X_____ Date_____

Signature of patient or responsible party if minor

MISSED APPOINTMENTS

I am aware that the I have to give the office a least 24 hour notice for an appointment that I will not be able to make. If I fail to do so there will be a charge to my account for the appointment time.

X_____ Date_____

Signature of patient or responsible party if minor

FINANCIAL ARRANGEMENTS

For your convenience, we offer the following methods of payments. Please check th option(s) which you prefer. Payment in full is expected at each appointment.

____ CASH ____ PERSONAL CHECK ____ CREDIT CARD (MOST TYPES)