



# WELCOME



Dr. John D. Stevens, DDS

Dr. Robert S. Landman, DMD

Thank you for selecting 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 contrary.

NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY, STATE, ZIP \_\_\_\_\_

BILLING ADDRESS 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 \_\_\_\_\_

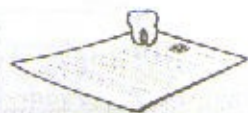
NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

## 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 added each month. 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 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 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 the option(s) which you prefer. Payment in full is expected at each appointment.

\_\_\_ CASH \_\_\_ PERSONAL CHECK \_\_\_ CREDIT CARD ( MOST TYPES)

