SILVESTRI & COMFORT
FAMILY DENTISTRY

Spouse or Responsible Party Information

The following is for: ☐ Patient's Spouse ☐ Dependent ☐ Patient

Patient Name: _____ Date: _____Gender: _____ Marital Status: _____

Date of Birth: _____ Social Security #: _____ Primary Phone: _____ ☐ Cell ☐Work ☐ Home

Address: _____

Employment Information The following is for: ☐ Person Responsible for Patient ☐ Patient

Employer Name: _____ Occupation: _____

Employer Address: _____ Employer Phone: _____

City: _____ State: _____ Zip Code: _____

Primary Insurance Information Patient's relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other:_____

Insured Name: _____ Insured Date of Birth: _____

ID #: _____ Group #: _____ Soc. Sec. #: _____

Insured's Address: _____ Apt#: _____

City: _____ State: _____ Zip Code: _____

Insured's Employer Name: _____ Address: _____

Insurance Company Name: _____ Address: _____

Secondary Insurance Information Patient's relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Insured Name: _____ Insured Date of Birth: _____

ID #: _____ Group #: _____ Soc. Sec. #: _____

Insured's Address: _____ Apt#: _____

City: _____ State: _____ Zip Code: _____

Insured's Employer Name: _____ Address: _____

Insurance Company Name: _____ Address: _____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. This 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, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental Insurance understand that all dental services furnished are charged directly to the patient and that you are 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 1.84% per month (22% per annum) on the unpaid balance will be charged on all accounts exceeding 90 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 assignee, at the time said services are rendered, or Within five (5) days of billing if credit shall be extended., unless written financial arrangements have been agreed upon. 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 content.

_____ Date: _____ Relationship to Patient: _____

Signature of patient, parent or guardian

Date: Relationship to Patient: