

Children's Dental Associates of New London County, P.C.

Patient Financial Understanding

MOTHER

Name: \_\_\_\_\_
First Middle Last
Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_
Month Day Year
Social Security No. \_\_\_\_/\_\_\_\_/\_\_\_\_
Marital Status: [ ] Single [ ] Married [ ] Separated
[ ] Divorced [ ] Widowed
Home Address:
Street \_\_\_\_\_
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_
Mailing Address if different from above:
Home Phone: \_\_\_\_\_
Cell Phone: \_\_\_\_\_
Email: \_\_\_\_\_
Employer: \_\_\_\_\_
Employer Address:
Street \_\_\_\_\_
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_
Title: \_\_\_\_\_ How Long: \_\_\_\_\_
Work Phone: \_\_\_\_\_ Ext \_\_\_\_\_

FATHER

Name: \_\_\_\_\_
First Middle Last
Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_
Month Day Year
Social Security No. \_\_\_\_/\_\_\_\_/\_\_\_\_
Marital Status: [ ] Single [ ] Married [ ] Separated
[ ] Divorced [ ] Widowed
Home Address:
Street \_\_\_\_\_
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_
Mailing Address if different from above:
Home Phone: \_\_\_\_\_
Cell Phone: \_\_\_\_\_
Email: \_\_\_\_\_
Employer: \_\_\_\_\_
Employer Address:
Street \_\_\_\_\_
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_
Position: \_\_\_\_\_
Title: \_\_\_\_\_ How Long: \_\_\_\_\_
Work Phone: \_\_\_\_\_ Ext \_\_\_\_\_

Child's Name \_\_\_\_\_
Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

DENTAL INSURANCE INFORMATION

Primary Insured Employee: \_\_\_\_\_
Employer providing insurance: \_\_\_\_\_
Name of Insurance Company: \_\_\_\_\_
Policy or Group # \_\_\_\_\_
Ins. ID # \_\_\_\_\_
Address of Insurance Company: \_\_\_\_\_
Secondary Insured Employee: \_\_\_\_\_
Employer providing insurance: \_\_\_\_\_
Name of Insurance Company: \_\_\_\_\_
Policy or Group # \_\_\_\_\_
Ins. ID # \_\_\_\_\_
Address of Insurance Company: \_\_\_\_\_
Nearest Relative not living with you:
Address: \_\_\_\_\_
Phone: \_\_\_\_\_

PATIENT FINANCIAL UNDERSTANDING

\*\*\*The person who brings the child to the visits is the person responsible for paying the child's dental care costs. You may pay by cash, personal check, Mastercard, Visa, Discover or pay on line through our website www.childrensdentalnlc.com \*\*\*

I, \_\_\_\_\_ residing at \_\_\_\_\_

hereby agree to be fully responsible for payment of all fees for services performed upon \_\_\_\_\_ including any amounts which are not covered by any dental insurance that I may have. I further agree to pay any collection cost, including but not limited to reasonable attorney's fees, court costs and/or collection costs, which may arise from non-payment of my account. Past due balances of 60 days or more will have a late payment penalty charge of 1.33% (16% per annum) added to them.

Signature of parent: \_\_\_\_\_ Date \_\_\_\_\_

Signature of parent: \_\_\_\_\_ Date \_\_\_\_\_

Signature of parent: \_\_\_\_\_ Date \_\_\_\_\_

I have reviewed the following treatment plan and fees. I agree to be responsible for all charges for dental services and materials not paid by dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to this claim.

Signed (Patient)

Date

I hereby authorize payment of the dental benefits otherwise payable directly to me to the below named dental entity. Children's Dental Associates of New London County P.C.

Signed (Employee/Subscriber)

Date

PLEASE REVIEW THE ABOVE INFORMATION AND SIGN THIS FORM ONCE A YEAR. IF THERE ARE ANY CHANGES PLEASE LET THE FRONT DESK KNOW AND FILL OUT A NEW FORM.

Signed \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Relationship to patient

Signed \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Relationship to patient