BEVERIDGE
DENTAL

Date: _____

Patient #: _____

Patient Information (confidential)

Name: _____ Birthdate: _____

Social Security #: _____ Driver's License #: _____

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed Spouse's name: _____

Employer: _____ Occupation: _____

Whom may we thank for referring you to our office? _____

Contact Information

Address: _____ City: _____ State: _____ ZIP: _____

Home phone: _____ Mobile Phone: _____

Email: _____

Name of School/college: _____ Students, please indicate how much you attend school: ☐ Part time ☐ Full time

School/college address: _____ City: _____ State: _____ ZIP: _____

Employer address: _____ City: _____ State: _____ ZIP: _____

Work phone: _____

Emergency contact: _____ Phone: _____

Best time to contact? _____ Where? _____

Responsible Party

☐ (Check box if same as above) Relationship to patient _____ Is this person currently a patient in our office? ☐ Yes ☐ No

Party responsible for this account: _____ Birthdate: _____

Social Security #: _____ Driver's License #: _____

Address: _____ City: _____ State: _____ ZIP: _____

Home phone: _____ Mobile Phone: _____

Email: _____

Employer: _____ Work phone: _____

Financial Institution: _____

Continued on reverse

Financial Information

Person responsible for payment for services:

I will be paying by (please check the appropriate boxes):

☐ Cash/Personal check ☐ Credit Card (VISA, MasterCard, American Express, Discover) ☐ Dental Insurance ☐ I would like to discuss an extended payment plan.

Primary Insurance Information

Name of insured: Relationship to patient:

Employer:

Union or Local #: Date employed:

Employer's address:

Insurance company: Insurance company's phone number:

Insurance company's address:

Policy name: Group#: Policy/ID#:

How much is your deductible? Max. annual benefit: How much have you used?

Additional Insurance Information

Name of insured: Relationship to patient:

Employer: Work phone:

Union or Local #: Date employed:

Employer's address: City: State: ZIP:

Insurance company: Insurance company's phone number:

Insurance company's address: City: State: ZIP:

Policy name: Group#: Policy/ID#:

How much is your deductible? Max. annual benefit: How much have you used?

I understand that this office requires financial arrangements to be made in advance, as a condition of my treatment. I understand that payment for dental services performed without previous financial arrangments are to be paid in full at the time services are rendered. In consideration for professional services rendered to me by the Doctor, I agree to pay the reasonable value of said services to said Doctor or his assignee at the time services are rendered. I further agree that the reasonable value of said services shall be as billed unless objected to by me, in writing, within the time for payment thereof. I 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 I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I understand that the fee estimate listed for my dental care can only be extended for a period of 90 days from the date of the patient examination.

I understand that the office of Dr. Stephen Beveridge will bill my insurance for me, as a courtesy. I furthermore understand that said dental office cannot render services on the assumption that charges will be paid in full by any insurance company. I understand that I am responsible for portions not covered by dental insurance which may include deductible, co-pay, co-insurance, UCR or non-covered services according to plan provisions.

I am aware that a service charge of 1.5 % (or 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, because appointment times are reserved especially for me, a courtesy notice of cancellation is required at least 48 hours prior to the time of appointment. The dental office will excuse the first occurence of appointments broken within the 48 hour period before my reserved appointment, after which a rescheduling fee of $100 will be charged for further occurences.

I have reviewed a copy of the Dental Material Facts sheet as required by law.

I grant my permission to the office of Dr. Stephen Beveridge 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.

Signature of patient (or parent / guardian if minor) Date