

RESPONSIBLE PARTY INFORMATION

(If different From Above or Insured)

Name _____
Last First Middle

Mailing Address _____
Street City State Zip

Street Address _____
Street City State Zip

How long at this address _____ Home Phone _____ Work Phone _____

Previous Address _____
(If less than 3 years) Street City State Zip

Social Security # _____ Date of Birth _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

SPOUSE'S INFORMATION

Name _____
Last First Middle

Social Security # _____ Date of Birth _____

Employer _____ Work Phone _____

DENTAL INSURANCE INFORMATION

Relationship of Patient to Insured: Self Spouse Child Other

Name of Insured _____ Subs SSN _____
(Subscriber) _____ BCBS # _____

Subscriber Date of Birth _____

Dental Insurance Co. _____

Group ID # _____

Pol. ID # _____

Name Of Plan _____ Plan # _____

Mail Ins. Claims To _____
Address _____
City _____
State _____

FINANCIAL POLICY FOR BLUE RIDGE GENERAL DENTISTRY

IT IS THE POLICY OF THIS OFFICE TO PROVIDE THE FINEST DENTAL CARE POSSIBLE. IN ORDER TO MAINTAIN THIS QUALITY OF CARE IT IS NECESSARY FOR US TO BE PAID FOR THE SERVICES PROVIDED. THIS POLICY EXPLAINS OUR EXPECTATIONS OF PAYMENT AND THE RESPONSIBILITY OF OUR PATIENTS.

Private Insurance:

Your insurance policy is an agreement between you and your insurance company. We will file your insurance for you but you are ultimately responsible for the bill if your insurance does not respond. We will send statements to patients when their insurance hasn't responded within ninety days of billing. Patients are responsible for their portion of the fee at the time of service.

No Insurance Coverage:

In the event that there is no dental care coverage, options for payment must be discussed *prior* to services being rendered. Payment will be expected at the time of service unless prior arrangements are made.

Elective Procedures:

Elective procedures are not covered by insurance. This office requires prepayment of all elective procedures, such as bleaching, veneers, and some crowns.

Ultimately, payment for the services provided to you in this office is your responsibility. You will receive a statement after we have requested payment from your insurance. After thirty days or your insurance has responded, you will be billed for your part. The account changes at that time from an insurance account to a patient account. If you are billed for services, payment is expected upon receiving the statement.

I understand that payment is expected at time services are rendered regardless if I have insurance. I also understand that all amounts owed are due within 30 days of statement date. PAST DUE amounts are subject to and will be charged 1.5% per month as a finance charge.

X (Patient) _____

X (Parent or Guardian) _____ Date _____