

Spouse or Responsible Party Information

The following is for: the patient's spouse the person responsible for payment **Employer** _____

Name: _____
 Male Female Married Single Child Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____

Address: _____
Street Apartment #

City State Zip Code

Insurance Information

Primary

Name of Policy Holder (Insured): _____ Is insured a patient? Yes No

Insured's Birth Date: _____ Social Security # _____

Insurance Plan Name: _____

Subscriber ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Patient's relationship to insured: Self Spouse Child Other _____

Secondary Insurance (If applicable)

Name of Policy Holder: _____ Is insured a patient? Yes No

Insured's Birth Date: _____ SSN#: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan Name and Address: _____

Referral Information

Whom may we thank for referring you to our practice? Another patient, friend Another patient, relative

Name of person or office referring you to our practice: _____

Passing By Yellow Pages Mailing School Work Insurance Plan Other _____

Consent for Services

I authorize Dr. Ausmer and his staff to perform dental treatment. As a condition of treatment by this office, patient portion is due at time of service.

I understand that a fee of \$40 will be charged for missed appointments or cancellations with less than 24 hours notice.

Patients with dental insurance coverage: I understand that all charges are billed to me directly and it is my responsibility to pay for services. We will assist in maximizing your insurance benefits. Please note that insurance coverage amounts are estimated until actual payments are received. Any outstanding portion will be my responsibility.

I understand any amounts not covered by insurance will be billed to me and due within 15 days of statement receipt.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 30 days. After 90 days past due, your account will be transferred to collections and a \$75 collection fee will be added to the account. This may also affect your status as an active patient.

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.

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.

 Signature of guarantor of payment/responsible party Date: _____ Relationship to Patient: _____



Midwest Smiles
FAMILY DENTISTRY