

Welcome to Trailside Dental Care

Our goal is to provide the highest quality of dental care possible and to have clear communication of our financial policy.

ALL ACCOUNTS ARE DUE AND PAYABLE AT TIME OF SERVICE. If a procedure requires multiple appointments, payment is required in full at the first appointment.

Payment options:

1. Cash
2. Check
3. MasterCard
4. Visa
5. Novus/Discover
6. Credit card authorization for recurring charges:
 - a. Treatment exceeds \$200
 - b. Plan may not exceed 4 months

Patient with insurance: The PATIENT is responsible for the ESTIMATED non-covered portion, procedures and/or deductibles at the time of the service, OR the patient can sign a credit card authorization to bill their credit card AFTER insurance has paid for the visit. If the insurance company does not pay after 60 days, we will bill you directly for the full balance.

Parents not accompanying their child to an appointment must make PRIOR arrangements for payment (cash, check or credit card authorization).

Parents accompanying their children are financially responsible for payment.

18% annual **interest** is charged for any unpaid balance. A \$15 fee is charged for nonpayment.

There is a \$30.00 processing charge for **non-sufficient funds** or returned checks.

Records can be viewed at any time. There is a nominal charge for release or copies of records.

Because instruments, chairs, and personnel are reserved exclusively for your appointment, there is a **\$25 - \$50 CHARGE FOR CHANGED OR BROKEN APPOINTMENTS LESS THAN 48 HOURS IN ADVANCE.**

I, _____, agree to these financial terms.

Signature _____ Date _____

PATIENT

PATIENT LAST NAME		FIRST	MIDDLE	PREFERRED NAME TO BE CALLED		TODAY'S DATE	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
BIRTH DATE	M.	D	YR	SOCIAL SECURITY NUMBER		HOME PHONE	<input type="checkbox"/> NONE MESSAGE PHONE	
						MARITAL STATUS <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> D <input type="checkbox"/> SEP		
MAILING ADDRESS				CELL PHONE	CITY		STATE	ZIP CODE
NEAREST FRIEND OR RELATIVE NOT LIVING WITH YOU			RELATIONSHIP	PHONE ()	E-Mail Address			
WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?							RELATIONSHIP	

FINANCIAL RESPONSIBILITY

PERSON RESPONSIBLE LAST NAME			FIRST	MIDDLE	RELATIONSHIP			
HOME PHONE		<input type="checkbox"/> SAME		SOCIAL SECURITY NUMBER			DRIVER'S LICENSE NUMBER	STATE
HOME ADDRESS					<input type="checkbox"/> SAME AS ABOVE		CITY	STATE
							ZIP CODE	
EMPLOYER		<input type="checkbox"/> SELF <input type="checkbox"/> NONE <input type="checkbox"/> RET		BUSINESS ADDRESS		BUS. PHONE	OCCUPATION	

IF PATIENT IS UNDER AGE 21

FULL TIME STUDENT <input type="checkbox"/> YES <input type="checkbox"/> NO	SCHOOL ATTENDING			CITY		GRADE	
BOTH PARENTS NAMES		MARITAL STATUS <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> D <input type="checkbox"/> SEP		IF PARENTS ARE DIVORCED, WHO HAS: LEGAL CUSTODY? <input type="checkbox"/> Mo <input type="checkbox"/> Fa FINANCIAL CUSTODY? <input type="checkbox"/> Mo <input type="checkbox"/> Fa			

PRIMARY DENTAL INSURANCE NONE PA, MEDICAID, (If None or PA, Turn Page Over)

INSURANCE COMPANY NAME	INSURANCE COMPANY ADDRESS			CITY		STATE	ZIP CODE
INSURANCE CO. PHONE NO.	SUBSCRIBER'S LAST NAME		FIRST	MIDDLE	SUBSCRIBER'S BIRTH DATE		
POLICY OR SOC. SEC. NO.	GROUP NO.	GROUP NAME		RELATIONSHIP OF PATIENT TO SUBSCRIBER <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER			

SECONDARY DENTAL INSURANCE NONE (If, Turn Page Over)

INSURANCE COMPANY NAME	INSURANCE COMPANY ADDRESS			CITY		STATE	ZIP CODE
INSURANCE CO. PHONE NO.	SUBSCRIBER'S LAST NAME		FIRST	MIDDLE	SUBSCRIBER'S BIRTH DATE		
POLICY OR SOC. SEC. NO.	GROUP NO.	GROUP NAME		RELATIONSHIP OF PATIENT TO SUBSCRIBER <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER			