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	☐ MALE ☐ FEMALE

BIRTH DATE M. D YR	SOCIAL SECURITY NUMBER	HOME PHONE ☐ NONE MESSAGE PHONE	MARITAL STATUS ☐S ☐M ☐W ☐D ☐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 ☐SAME	SOCIAL SECURITY NUMBER	DRIVER'S LICENSE NUMBER	STATE

HOME ADDRESS ☐SAME AS ABOVE	CITY	STATE	ZIP CODE

EMPLOYER ☐SELF ☐NONE ☐RET	BUSINESS ADDRESS	BUS. PHONE	OCCUPATION

IF PATIENT IS UNDER AGE 21

FULL TIME STUDENT ☐YES ☐NO	SCHOOL ATTENDING	CITY	GRADE

BOTH PARENTS NAMES	MARITAL STATUS ☐S ☐M ☐W ☐D ☐SEP	IF PARENTS ARE DIVORCED, WHO HAS: LEGAL CUSTODY? ☐Mo ☐Fa FINANCIAL CUSTODY? ☐Mo ☐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 ☐SELF ☐SPOUSE ☐CHILD ☐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 ☐SELF ☐SPOUSE ☐CHILD ☐OTHER