WELCOME TO THE DENTAL OFFICE OF
ROD P. MAXFIELD, DDS, INC.

PATIENT INFORMATION

Patient Name _____

M_____ F_____ Birth date_____ Age_____

Lives With: Self____ Spouse____ Other_____

Address _____

City_____ State_____ Zip_____

Home Ph# _____ Work Ph# _____

Cell Ph# _____ Soc. Sec. # _____

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT

Name _____

Address_____

City _____ State_____ Zip _____

Home Ph# _____ Work Ph# _____

Cell Ph# _____ Soc. Sec. # _____

Email address for appt. confirmations _____

Person to contact in case of emergency _____ Phone# _____

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

INSURANCE INFORMATION

(Primary Insurance)

Policy Holder_____

Birth date _____ Ins. ID# _____

Employer _____Phone# _____

Insurance Company _____

Address _____

City _____ State ____ Zip _____

Insurance Co. Phone# _____

(Secondary Insurance)

Policy Holder _____

Birth date _____ Ins. ID # _____

Employer _____Phone# _____

Insurance Company _____

Address _____

City _____ State _____ Zip _____

Insurance Co. Phone# _____

FINANCIAL POLICY & AGREEMENT:

1. Payment for services is due at the time of treatment.
2. Estimated Insurance co-payment and deductible amounts are due at the time of treatment.
3. ____ We will happily assist you in billing your primary insurance for 90 days, after which, the entire amount will become the patient's responsibility.
4. ____ Balances unpaid after 90 days will be charged interest of 1.5% monthly (18% annually) and incur a $5.00 per month billing fee.
5. Missed appointments & cancellations made without 24 hours notice will be charged $25.00.
6. If action or suit is necessary to collect a delinquent balance, the patient and/or responsible party shall be liable for collection costs including attorney/court fees plus added interest of 40%.
7. *We offer a discount for complete payment at the time of service.*
   (10% for cash or check, 7% for credit card).
8. Payment plans are available. Would you like to apply for credit? (please circle one) Yes / No
9. ____ I agree to receive texts regarding my account.

I certify that the information given herein is true and correct and accept the terms of this agreement.

Date _____ **Signature of Responsible Person** _____

INSURANCE ASSIGNMENT AND RELEASE OF INFORMATION

I hereby authorize my insurance to make payment directly to the dentist. I understand that I am ultimately responsible for all costs of dental treatment no matter what the insurance company may or may not pay. I further authorize release of any medical/dental information requested.

Date _____ **Signature of Responsible Person** _____