ALLEN HEIGHTS DENTAL

Dear Patient, the primary mission of Allen Heights Dental is to deliver the finest and most comprehensive healthcare available, in a cost-effective manner.

Payment of your services is acceptable with:

Cash/Check/Visa/MasterCard/Discover/American Express/Care Credit

INITIAL _____ PAYMENT IS DUE AT THE TIME OF TREATMENT

Dental Insurance: (Please fill out completely)

Subscriber Name:_____ DOB_____

Relationship to Patient:_____

Address (if different from patient):_____ SSN _____

Subscriber employed by:_____ Business Phone # _____

Insurance Company:_____ Phone # _____

Insurance Company Address:_____ Subscriber id _____

INITIAL _____ As a courtesy, we file your primary insurance. However, any balance not paid by your insurance company within 45 days of services performed, will be the responsibility of the patient

I authorize my insurance company to pay the doctor, all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions

I authorize the doctor to release all information necessary to secure payment of benefits. I grant permission to use my records for publication in scientific and professional journals and presentations at any time during or after treatment with the understanding that my identity will remain confidential. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on behalf of my dependents.

Signature: _____ Date: _____