



FINANCIAL OPTIONS FORM

I, _____, choose the following financial option for my dental care and for the care of my dependents (if any):

Please initial one of the following:

1. I elect to pay cash _____, check _____, Mastercard _____, Visa _____, Discover _____, AmEx _____, at each appointment as treatment progresses.
2. I wish to apply for your in-office finance plan with Capital One Healthcare Finance, Care Credit or other similar programs offered by our office. I understand that on approved credit, I may finance my entire treatment by Capital One, Care Credit or other similar programs, paying Advanced Dental Technology II, PLLC in full and then making my monthly payments to Capital One Healthcare Finance, Care Credit or another similar program. **For details, see the receptionist.**
3. For treatment over \$400 and requiring more than one visit to complete the service, I elect to pay half on preparation date and the balance at the second appointment.

Although our office does not participate with any insurance company, we can process your insurance to them as a courtesy to you. Predeterminations can also be processed to help you be aware of what may be reimbursed to you after your treatment is complete.

Patient Signature _____ Date _____

Responsible Party _____ Date _____

Witness/Office Member _____ Date _____

PATIENT INFORMATION

Today's Date ____/____/____
Patient Name (First, MI, Last) _____
Address _____
City, State, Zip _____
Home Telephone _____ Work Telephone _____
Social Security No. ____ - ____ - ____ Date of Birth ____/____/____ Age ____
If patient is a minor, give parent's or guardian's name: _____
How did you hear about our office? _____

ACCOUNT BILLING INFORMATION (Person responsible for payment)

Last Name _____ First Name _____ MI _____
Residence _____ City, State, Zip _____
Mailing Address: _____ City, State, Zip _____
Social Security No. ____ - ____ - ____ Date of Birth ____/____/____
Driver's License # _____ State _____ How long at this address? _____
Previous Address (if current less than 3 years) _____
Employer _____ Work Phone _____

DENTAL INSURANCE INFORMATION

(Primary Carrier)

Insured's Name _____

Insurance Co _____

Address _____

Telephone _____

Insured's SS # . ____ - ____ - ____

Birthdate ____/____/____

(Secondary Carrier)

Insured's Name _____

Insurance Co _____

Address _____

Telephone _____

Insured's SS # . ____ - ____ - ____

Birthdate ____/____/____

EMERGENCY INFORMATION

Relative not living with you

Name _____

Relationship _____

Address _____

City, State, Zip _____

Telephone _____

RESPONSIBLE PARTY SPOUSE INFO

Name _____

Employer _____

Occupation _____

Work Phone _____

SS No. _____

Birthdate _____

Appointment Policy:

Once an appointment has been scheduled please remember that this time has been reserved exclusively for you. Since your care is our utmost concern and your time is as valuable as ours, we do not overbook our schedule. If you miss an appointment, other patients who are awaiting urgent care are delayed in receiving their treatment. An appointment missed or canceled without prior notification of at least 24 hours may be subject to a charge of \$15 per 15 minutes of scheduled time.

Signature _____ Date _____