## FINANCIAL POLICIES AND DISCLAMERS

Patient Name _____ Marital Status _____

SS# _____ Birth Date _____ M / F

Responsible Party _____

SS# _____ Birth Date _____

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____

Cell Phone _____ Email Address_____

The financial policy of our office is to request payment at the time of service. Courtesies are extended to our seniors and we offer prompt payment incentives. We accept cash, personal check, Visa, Master Card, Discover Card, and Debit Cards.

Credit Card _____ Account # _____

Expiration Date _____ Authorized Signature _____

**For your information this office uses composite (tooth colored) fillings only. We do not use amalgam (silver) fillings. There are several reasons why, including the fact that these fillings adhere to teeth and strengthen them. Our treatments are based on the health of our patients not the dictates of insurance policies. Please contact your insurance company for their provisions if you are an insured patient. We hope you appreciate the use of this.**

I HAVE NO DENTAL INSURANCE

A. I will pay with cash _____, Check_____, Credit Card _____ on the date of service.

B. When a lab fee is involved I will pay 1/3 on the preparation date, 1/3 on the impression date and the balance due upon delivery.

C. For extended services I would like to apply for 3rd party financing. _____ (Initial)

I have reviewed and understand the office policies.

_____
(Patient / Parent)

**(OVER)**