PATIENT INFORMATION

Name:_____ SEX _____ DATE OF BIRTH_____SOCIAL SECURITY NUMBER_____

Local Address

- City,State,Zipcode

Out Of Town Address

- City,State,Zipcode

Local Home phone number | Local Cell Phone Number

- Out Of Town Home Number | Out Of Town Cell Phone Number

E-Mail Address | Work Phone Number

- Employer | Employer Address

Marital Status | Spouse Name

- Minor's Mother's Name/Social Security/Date of Birth | Minor's Father's Name/Social Security/Date of Birth

Emergency Contact | Emergency Contact Number

- Who may we thank for your referral to our office?

Insurance Information | Name of Policy Holder

- Date of Birth | Social Security Number | Relationship to Patient

Dental Policy Name | Group #/ID

- Dental Carrier Address | Dental Carrier Phone Number

Medical Policy Name | Group#/ID

- Medical Carrier Address | Medical Carrier Phone Number

Policy Holder's Employer | Employer Phone #

- Employer Address | Occupation

I will be paying today with cash_____ check_____ credit card_____ care credit_____ retriever_____

I understand and agree that I am ultimately responsible for payment.

I certify that this information is true and correct to the best of my knowledge.

Signature _____Date_____Witness_____

Patient Information

Welcome to Dr. Walsh's office. It is to our mutual benefit that our patients understand our Payment Policy . We make every effort to keep the cost of your care to a minimum. Due to the expense and time involved for processing insurance claims , we ask that you pay your portion at the time of your visit. As a courtesy, we will bill your insurance company, ultimately, the responsibility for payment lies with the patient. Payments not received from the insurance company within 45 days of filing becomes the responsibility of the patient. Please sign the following authorization so that payment may be made to Thomas M. Walsh II,D.D.S. P.A. for services rendered and billed by Thomas M. Walsh II,D.D.S., P.A.

Patient : _____

Our Payment/Insurance Policy

I, the undersigned, hereby authorize Thomas M. Walsh II,D.D.S.,P.A. to apply for benefits on my behalf for the services rendered to me, not paid in full today.

I REQUEST PAYMENT FROM MY INSURANCE CARRIER,IF ANY, BE MADE DIRECTLY TO THOMAS M. WALSH II,D.D.S.,P.A. UNLESS OTHERWISE INDICATED ON THE CLAIM.

I certify that the information reported with the regard to insurance coverage is correct and further authorize the release of any necessary information, including dental or medical information, for this or any related changes not paid under this insurance policy.

Release Information

I consent to the taking of x-rays, photographs, and data before, during, and after treatment , as they are a necessary part of diagnostic and record keeping procedures.

I further give my permission, to Dr. Walsh, for the use of these x-rays, photographs, and records to be used for the purpose of research, education or professional publications. INITIAL : _____

Dr. Walsh may disclose any or part of my dental/medical records to my insurance company (or companies) for purposes to satisfying charges billed .

Guarantee Of Payment

To Dr. Thomas Walsh II: For the consideration of services rendered, or to be rendered to the above named patient. I guarantee payment of all said charges incurred in accordance with the policy of payment of bills. Interest on the unpaid balance at the rate of 25% per annum will be accrued 45 days after the services rendered . In the event the account must be placed with an attorney or collection agency to obtain payment , I shall be responsible for all attorney and collection agency fees incurred.

THE UNDERSIGNED HAS READ AND UNDERSTANDS THE ABOVE TERMS AND CONDTIONS.

Signature: _____ Date: _____ Witness: _____