



CRIMSON RIDGE  
DENTISTRY

### Responsible Party Information

Name of person financially responsible: \_\_\_\_\_  
Relationship to patient: \_\_\_\_\_  
Social Security # \_\_\_\_\_ Birthdate: \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State & Zip Code: \_\_\_\_\_  
Method of payment:  Cash  Check  Credit Card  
Bank: \_\_\_\_\_ Account # \_\_\_\_\_  
Credit Card: \_\_\_\_\_ Account # \_\_\_\_\_

### Employment Information

Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Employers Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
Spouse Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Employers Address: \_\_\_\_\_ Phone: \_\_\_\_\_

### Insurance Information

**Primary**  
Name of Insured: \_\_\_\_\_ Is insured a patient?  Yes  No  
Insured's Birth Date: \_\_\_\_\_ Insured's Social Security Number: \_\_\_\_\_  
Insurance ID #: \_\_\_\_\_ Group #: \_\_\_\_\_  
Insured's Address: \_\_\_\_\_  
Insured's Employer Name: \_\_\_\_\_  
Patient's relationship to insured:  Self  Spouse  Child  Other  
Insurance Plan Name and Address: \_\_\_\_\_

**Secondary**  
Name of Insured: \_\_\_\_\_ Is insured a patient?  Yes  No  
Insured's Birth Date: \_\_\_\_\_ Insured's Social Security Number: \_\_\_\_\_  
Insurance ID #: \_\_\_\_\_ Group #: \_\_\_\_\_  
Insured's Address: \_\_\_\_\_  
Insured's Employer Name: \_\_\_\_\_  
Patient's relationship to insured:  Self  Spouse  Child  Other  
Insurance Plan Name and Address: \_\_\_\_\_

### Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot renderservices on the assumption that our charges will be paid by an insurance company.

A service charge of 1 1/2% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previous written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder. "IN THE EVENT OF NON-PAYMENT OR DEFAULT, I AM RESPONSIBLE FOR ALL COST OF COLLECTIONS, INCLUDING BUT NOT LIMITED TO COLLECTION AGENCY FEES, COURT COST, AND REASONABLE ATTORNEY FEES."

I grant my permission for you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

Signature of guarantor/responsible party of payment \_\_\_\_\_ Date \_\_\_\_\_ Relationship to patient \_\_\_\_\_