Patient Information - Getting to Know You!

Patient's Name _____ Date _____ Referred by _____

Date of Birth _____ Social Security Number _____ Marital Status_____

Home Address _____
Street Address City State Zip

Where may we reach you during business hours? _____ _____
Home Work

Cellphone Number _____ Email address _____

Occupation _____ Employer Name & Address _____

Spouse's Name _____ Spouse's Occupation_____ Work Number _____

Who is responsible for payment of this account? _____ Relationship to Patient_____

Social Security No. _____ Date of Birth_____

Dental Insurance Benefit Information:

Primary Coverage:

Employee Name _____SSN _____

Date of Birth _____Employer_____

Insurance Co. _____

Group No. _____ Phone _____

Secondary Coverage:

Employee Name _____SSN _____

Date of Birth _____Employer _____

Insurance Co. _____

Group No. _____ Phone _____

Insurance Assignment of Benefits:

As your dental care provider, our relationship is with you, the patient, not with your insurance company. Your insurance policy is a contract between you, your employer and the insurance company. As a courtesy, to you, we will complete insurance forms, submit a claim on your behalf and help you in any we can to maximize your insurance benefits. We are required to collect your co-payment at every visit. You are responsible for payment in full of any balance on your account for services rendered that are not paid by your insurance company within 45 days. We can only accept direct payments from your insurance with your permission. By signing below, you agree that you have read this section and authorize our office to accept an assignment of benefits from your insurance company .

Name_____ Date: _____

You may also pre-authorize us to charge your credit card for balances on your account not covered by your insurance company:
I authorize Michael J. Rogers, D.D.S. PC or Jonathon M. Rogers, D.M.D. to keep my signature on file and charge my account for:

- ☐ Balance of charges not paid by insurance within 45 days and not to exceed $ _____ for:
  - ☐ this visit only ☐ all visits this year
  - ☐ recurring charges (ongoing treatments) of $ _____every _____ from _____to _____

Cardholder name:_____ Billing Address _____
Card of choice: MC ___Visa ___ Discover ___Debit ____ Card No. _____

Cardholder Signature _____ Exp. Date_____ Today's Date _____

Our Financial Policy: Payment is to be made at the time services are rendered. We do have several options for outside patient financing for qualifying patients which we would be happy to tell you about. Should your account ever become over 120 days past due, please read and sign the following: In the event my account is turned over to an attorney and/or a collection agency, I agree to be responsible for the payment of any collection fees, reasonable attorney fees, court costs or any other costs incurred in the collection of my account.

Name_____ Date _____