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FINANCIAL RESPONSIBILITY FORM

RESPONSIBLE PARTY NAME: ______________________________

PATIENTS NAME: ______________________________

PATIENTS DATE OF BIRTH: ______________________________

SOCIAL SECURITY NUMBER (parents SS# if patient is a child)
____

ADDRESS: ______________________________

CITY, STATE, ZIP: ______________________________

HOME # ______________________________

CELL # ______________________________

EMPLOYER: ______________________________

WORK # ______________________________

This office is happy to cooperate with individuals who are covered by dental insurance. We only ask that you carefully read your policy to be sure that you are fully aware of any restrictions that apply to the benefits provided. Dental insurance is a contract between the patient and the insurance company for reimbursing the cost of dental services. It is not a contract between the dentist and the insurance company. I understand that I am financially responsible for all services rendered by the Dentist. I understand any co-payments, deductibles, and/or procedure cost not covered or denied by my insurance company, (including coverage termination prior to the date of services are rendered) are my responsibility.
This Dental office is authorized to fill out and/or assist me to complete any and all insurance forms pertaining to services rendered.

<u>IF PAYMENT ARRANGEMENTS NEED TO BE MADE, THEY MUST BE MADE PRIOR TO TREATMENT BEING RENDERED</u>

Signature ______________________________ Date ________________