OFFICE USE ONLY

Insurance Benefits Information

PRIMARY

Insurance name _____ Phone # _____

Group # _____

Billing address _____

_____

Coverage **effective** date _____ **Coverage:** calendar year / other _____ to _____

Pre-authorization $_____ **Deductible:** yearly / lifetime $_____

Yearly maximum $_____ **Preventative** %_____ of reasonable and customary

Basic % _____ of reasonable and customary **Major** % _____ of reasonable and customary

Xrays are needed for what procedures _____

SECONDARY

Insurance name _____ Phone # _____

Group # _____

Billing address _____

_____

Coverage **effective** date _____ **Coverage:** calendar year / other _____ to _____

Pre-authorization $_____ **Deductible:** yearly / lifetime $_____

Yearly maximum $_____ **Preventative** %_____ of reasonable and customary

Basic % _____ of reasonable and customary **Major** % _____ of reasonable and customary

Xrays are needed for what procedures _____

Patient or Responsible Party Information

The following is for (circle one) patient person responsible for payment

Lone Mountain Family Dentistry
461 Hot Springs Rd.
Carson City, NV 89706
(775) 883-1092

Name _____

(circle one) Male Female (circle one) married single child other

Social Security # _____ Birth Date _____

Phone: home _____ work _____ Ext _____ cell _____

Address: _____

_____

Employment Information

The following is for (circle one) patient person responsible for payment

Employer Name _____ Occupation _____

Employer Address _____

Insurance Information

Primary

Name of Insured _____ Is insured a patient yes no Insured's Birth Date _____ SS# _____

Patient's relationship to insured self spouse child other _____

Insured's Address _____

Insured's Employer Name _____

Employers Address _____

Insurance Plan Name and Address _____ group # _____

_____

Secondary

Name of Insured _____ Is insured a patient yes no Insured's Birth Date _____ SS# _____

Patient's relationship to insured self spouse child other _____

Insured's Address _____

Insured's Employer Name _____

Employers Address _____

Insurance Plan Name and Address _____ group # _____

_____

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 at the time services are performed.
A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 30 days.
I understand that the fee estimate for dental care can only be extended for a period of six months from the date of the estimate.
In consideration for the professional services rendered to me, I agree to pay at the time said services are rendered, or within five (5) days of billing if credit shall be extended.
Signature on File: - I authorize: a copy of this form may be used in place of the original, use of this form on all of my insurance submissions, release of information to all of my insurance carriers, for doctor to obtain payment from insurance carriers, and direct payment from insurance carriers to doctor.
I understand that I am responsible for the entire amount of my bill.

_____ Date _____ Relationship to Patient: _____

Print name of responsible party

_____ In case of emergency contact: Name _____

Signature of responsible party

Phone _____