PERSON RESPONSIBLE FOR ACCOUNT

NAME (Print): **Sex:** **Birthday:** **SS #:**

MAILING ADDRESS: **E-MAIL ADDRESS:** **CELL PHONE:**

EMPLOYER AND EMPLOYER ADDRESS: **WORK PHONE:**

SPOUSE INFORMATION:

NAME (Print): **Sex:** **Birthday:** **SS #:**

MAILING ADDRESS: **E-MAIL ADDRESS:** **CELL PHONE:**

EMPLOYER AND EMPLOYER ADDRESS: **WORK PHONE:**

DEPENDENT INFORMATION:

Name:	Sex:	Birthday:	Social Security #:

DENTAL INSURANCE INFORMATION:

INSURANCE COMPANY NAME:

PHONE:

WHO IS COVERED? (Please Circle)

Husband Wife Dependents

GROUP NUMBER (If Any):

SPOUSE'S INSURANCE COMPANY NAME:

PHONE:

WHO IS COVERED? (Please Circle)

Husband Wife Dependents

GROUP NUMBER (If Any):

I authorize Dr. Gorman to submit claims for payment for services to the insurance companies named above, on my behalf and in my name. I assign to Dr. Gorman the insurance benefits otherwise payable to me. I also authorize Dr. Gorman to release to the listed insurance companies or their representatives any and all information and records (including x-rays) concerning my or my dependent's medical history that are needed to review, investigate or evaluate any claim for benefits.

Should no insurance payment be made within ninety days of a submitted claim, the fee will become the sole responsibility of the patient. Any balance remaining after all insurance payments are received is the responsibility of the patient. Finance charges will apply to this unpaid balance.

PAYMENT IN FULL FOR SERVICES RENDERED IS EXPECTED AT EACH APPOINTMENT UNLESS PRIOR FINANCIAL ARRANGEMENTS HAVE BEEN MADE. A FINANCE CHARGE of 1 ½ % PER MONTH (18% per year) WILL BE ASSESSED ON PAST DUE ACCOUNTS PLUS A $20.00 LATE CHARGE WILL APPLY TO ANY PAYMENT NOT RECEIVED ON THE AGREED DUE DATE.

SIGNATURE: ______________________________ DATE: ______________

"THANK YOU FOR SELECTING OUR OFFICE FOR YOUR DENTAL CARE!"