DENTAL INSURANCE

Subscriber's Name____

Date of Birth___________________Social Security Number__________________________

Relationship to patient____

Insurance Co.____

Group Number____

Employer____

FINANCIAL COMMITMENT

I understand responsibility for payment of Dental Services provided in this office for my dependents and myself is mine, due and payable at the time services are rendered unless other financial arrangements have been made with this office. In the event payments are not received by agreed upon dates, I understand that a 1½% finance charge (18% annual percentage rate) may be added to my account.

Patient Signature____Date____________

Parent/Responsible Party Signature_________________________________Date____________

PATIENT CONSENT

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment.

Patient Signature____Date____________

Parent/Responsible Party Signature___________________________________Date____________

AUTHORIZATION FOR SUBMISSION OF CLAIMS AND ASSIGNMENT OF BENEFITS

I authorize the office of Martin C. Cuellar, D.D.S. & Jessica A. Caballero, D.D.S. to submit claims for payment for services to the health care service plan or insurance company named below, on my behalf and in my name, and assign such provider the group insurance benefits otherwise payable to me. I understand that I am financially responsible for any balances not satisfied by my insurance benefits, regardless of the basis for nonpayment by my insurance carrier.

Insurance Company____

Patient Name (if Minor, Parent/Guardian)____

Signature____Date____________

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I authorize the office of Martin C. Cuellar, D.D.S. & Jessica A. Caballero, D.D.S. to provide any insurance company, health care service plan, self insurers, or their representatives, any and all information and records (including x-rays) about my medical history, or about services rendered or treatment given to me, that are needed to review, investigate or evaluate any claim for benefits. If my coverage is under a group master agreement held by my employer, an association, trust fund, union or entity, this authorization also permits disclosure to them for purpose of utilization review or financial audit.

Patient Name (if Minor Parent/Guardian)____

Signature____Date____________

CONSENT TO PHOTOGRAPH

I permit the dentist to photograph as a part of the documentation of my/the patient's dental condition. These photographs will be maintained as part of my/the patient's permanent dental record.

Patient/Guardian Authorized Signature_________________________________Date___________