ANGELA B. BATESON, DDS

GENERAL DENTISTRY
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RESPONSIBLE PARTY INFORMATION

Name _____ ❑Male ❑Female
LAST FIRST MIDDLE INITIAL

SS# _____ Birth date _____

Home #_____ Work/Ext # _____ Cell # _____ Best time to call _____

Address _____ Email _____
STREET/ CITY-STATE-ZIP

Responsible party's employer_____ Occupation _____

Address_____
STREET/ CITY-STATE-ZIP

MEDICAL INSURANCE INFORMATION

PRIMARY INSURED

Name of insured_____ Is insured a patient? ❑Yes ❑No

Insured's birth date_____ ID #_____ Group #_____

Insured's address_____
STREET/ CITY-STATE-ZIP

Insured's employer name _____

Insured's employer address_____

Patient's relationship to insured: ❑ Child ❑Other _____

Name / address of insurance plan _____

_____

SECONDARY INSURED

Name of insured_____ Is insured a patient? ❑Yes ❑No

Insured's birth date_____ ID #_____ Group #_____

Insured's address_____
STREET/ CITY-STATE-ZIP

Insured's employer name _____

Insured's employer address_____

Patient's relationship to insured: ❑ Child ❑Other _____

Name / address of insurance plan _____

_____

FINANCIAL AGREEMENT. FINANCIAL ARRANGEMENTS WILL BE MADE WITH YOU BEFORE ANY TREATMENT IS RENDERED. All emergency dental treatment or any dental treament performed without prior financial arrangements will be paid for at the time of service. Patients who carry dental insurance understand that all dental treament provided is performed directly for the patient and that you or your repsonsible party are personally responsible for payment of all treatment. A service charge of 21% per annum will be charged on the unpaid balance of all accounts over 60 days. I understand that when appropriate, credit bureau reports may be obtained. I grant my permission to your office to telephone me at my home or work to discuss matters related to this form or my dental treatment.

SIGN HERE _____
SIGNATURE OF PATIENT OR RESPONSIBLE PARTY TODAY'S DATE