Camillo L. Fontana, DMD, LLC

PATIENT INFORMATION

Patient Name:_____Title: □Mr. □Mrs. □Ms. □Other___
Last, First, MI
Birthdate:_____ SS#_____ □Single □Married □Widowed □Divorced Gender:_____
Address_____
Street and or Apartment #

_____
City State Zip Code
Home Phone:( )_____Work( )_____Cell ( )_____
Employer:_____Occupation:_____
Emergency Contact:_____Relationship:_____Phone:_____
Email Address:_____

Preferred contact: ( )Home ( ) Cell ( )Email_____ ( )Text (Cell Provider)_____

Whom may we thank for referring you?_____

RESPONSIBLE PARTY INFORMATION

Responsible Party:_____Relation to Patient:_____Phone#:_____

Address:_____
Street Unit#

_____
City State Zip Code

CONSENT FOR SERVICES

All dental service provided, emergency or scheduled, must be paid at the time of service unless a previous financial arrangement has been made. A finance charge of 1½% per month(18%annual) on unpaid balances will be charged on all accounts exceeding 90 days, unless previously written financial arrangements are satisfied. Treatment plan estimates can only be extended for six months from the date of issuance.

Patients who have dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment. This office will help prepare the insurance forms or assist in making collections from insurance companies and will credit or refund any such collections to the patient's account.

I have read and understand the above conditions of treatment and payment and agree to their content.

_____Date:_____Relationship to Patient:_____
Signature of patient(parent or guardian if under age 18)

Primary Dental Insurance Information

Name of Insured:_____ Is the insured a patient? □Yes □No
Last First MI
Patient's relationship to insured:_____Insured SS#_____
Insured Employer:_____Insured's Birth date:_____
Address:_____
Street City State Zip
Insurance Plan Name and Address:_____

_____
Group#:_____ ID#:_____Do you have Secondary Insurance? □YES □NO

Assignment of Benefits & Release of Information

I, the undersigned, certify that I have insurance coverage as stated above and assign directly to Camillo L. Fontana, DMD, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize use of this signature on all insurance submissions.

Responsible party signature:_____Date:_____