PERSONAL DATA

PATIENT'S LAST NAME _____ FIRST NAME _____ MIDDLE _____ DATE _____

CURRENT STREET ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

HOME PHONE _____ WORK PHONE _____ MOBILE PHONE _____ EMAIL _____

SOCIAL SECURITY NUMBER _____

PLEASE CIRCLE: SINGLE MARRIED DIVORCED OTHER

PLEASE CIRCLE: MALE FEMALE

PATIENT'S BIRTHDAY _____ WHO CAN WE THANK FOR REFERRING YOU TO OUR PRACTICE _____

WHO TO CONTACT IN CASE OF EMERGENCY _____ RELATIONSHIP _____ PHONE _____

A NEIGHBOR WE COULD CONTACT _____ PHONE _____

RESPONSIBLE PARTY FINANCIAL INFORMATION

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT _____ RELATIONSHIP _____

CURRENT STREET ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____ HOME PHONE _____

EMPLOYER NAME _____ EMPLOYER ADDRESS _____ WORK PHONE _____

SOCIAL SECURITY NUMBER _____ BIRTHDATE _____

DENTAL INSURANCE INFORMATION

PRIMARY INSURANCE

POLICY HOLDER'S FULL NAME _____ SOCIAL SECURITY NUMBER _____ BIRTHDATE _____

EMPLOYER'S NAME EMPLOYER'S _____ FULL ADDRESS WORK _____ PHONE _____

INSURANCE COMPANY NAME _____ INSURANCE COMPANY FULL ADDRESS _____

INSURANCE PHONE _____ GROUP NUMBER _____ EMPLOYEE ID NUMBER _____

SECONDARY INSURANCE

POLICY HOLDER'S FULL NAME _____ SOCIAL SECURITY NUMBER _____ BIRTHDATE _____

EMPLOYER'S NAME EMPLOYER'S _____ FULL ADDRESS WORK _____ PHONE _____

INSURANCE COMPANY NAME _____ INSURANCE COMPANY FULL ADDRESS _____

INSURANCE PHONE _____ GROUP NUMBER _____ EMPLOYEE ID NUMBER _____

Our oral health team provides optimal dental care while striving to help our patients feel comfort and satisfaction. Following your diagnosis, the doctor will advise you of the best plan of treatment. Additionally, we will always discuss with you the fee for service for today and future treatment.

PAYMENT FOR TODAY'S VISIT AND YOUR FUTURE VISITS ARE DUE AT THE TIME SERVICE IS RENDERED. We are sensitive to the fact that some patients may not be able to pay cash for their treatment. Therefore, we do offer alternative payment programs for your convenience.

WE ACCEPT MOST INSURANCE PLANS AND WILL FILE THEM AS A COURTESY FOR YOU.

ALL ACCOUNTS ARE HANDLED IN THE FOLLOWING MANNER:

1. Payments, including copayments and deductibles are expected when services are rendered.
2. Mastercard, Visa, American Express or Discover Card accepted.
3. We offer an extended payment plan with prior credit approval.

Balances older than 60 days may be subject to an interest charge of 2% per month (24% annual rate). Any accounts that are not paid in full within 90 days of treatment will be transferred over to our collection agency if no prior arrangements have been made with our accounts manager. Should the account be referred to an attorney or collection agency, the responsible party will be liable to pay up to a 50% collection fee as well as reasonable court and attorney fees.

REGARDING INSURANCE:

1. Your insurance is a contract between you, your employer and the insurance company. We are not party to that contract.
2. If your insurance company has not paid in full within 90 days, the balance will automatically become your responsibility.
3. Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

We must emphasize that as dental care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered.

USUAL AND CUSTOMARY RATES

Our fees are generally considered to fall within the acceptable range by most insurance companies, and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage (such as 50% or 80%) of"U.C.R:'. "U.C.R:' is defined as usual, customary, and reasonable fees for this region. Thus, our fees are considered usual, customary and reasonable by most companies. This statement does not apply to companies who reimburse based on an arbitrary "schedule" of fees, which bears no relationship to the current standard and cost of care in this area.

MISSED APPOINTMENTS

Unless canceled at least 24 hours in advance, our office policy is to charge $20.00 per hour for missed appointments. We understand how valuable your time is and our time is just as valuable.

If you have any questions about the above information or any uncertainty regarding insurance coverage, please don't hesitate to ask us. We are here to help you.

FINANCIAL AGREEMENT - I have read the above policies and understand that I am responsible for the cost of collection and/or attorney's fees if any delinquent balance is placed with an agency for collection or suit.

Signature _____ Date _____

ASSIGNMENT AND RELEASE OF INFORMATION - I hereby authorize my insurance to make payment directly to Dr. Jarman. I understand that I am responsible for all costs of dental treatment. I further authorize the release of any Medical/dental information requested.

Signature _____ Date _____