Grove Endodontics PA • Thomas Waldron, D.D.S. • 8811 92nd Street South, Suite 109 • Cottage Grove, MN 55016 • (651) 768-8180

Patient Information

Date: ________________

Name: ____

Address: ____

City: ______________________ State: ______ Zip: ______________

Home Phone: ____________________ Cell Phone: ____________________

Work Phone: ____________________

Birth Date: ____________________ Sex: ❑ Male ❑ Female

Social Security#: ____

Emergency Contact Name and Phone: ______________________________

Person Responsible for Account (If a Minor): ______________________

Primary Insurance

Policy Holder's Name: ______________________ Relationship: ____________

Social Security #: ______________________ Birth Date: ____________

Employer: ____

Insurance Company: ____

Secondary Insurance

Policy Holder's Name: ______________________ Relationship: ____________

Social Security #: ______________________ Birth Date: ____________

Employer: ____

Insurance Company: ____

We will request a copy of your insurance card(s) to obtain information regarding your subscriber ID(s) and group number(s), as well as the address of your insurance company(s).

OVER ⇨

Financial Agreement Record

1. **Patients without dental benefits:**
   Cash, check, or credit card (Visa or MasterCard) for payment in full. We will extend a 5% bookkeeping savings.

2. **Patients with dental benefits:**
   We require all insurance co-payments and deductibles be paid in full at the time of service.

   Insurance coverage is estimated from information provided by the insurance carrier and is not a guarantee of coverage or payment amount. The patient and/or responsible party understands that any balance due will be billed to them and due upon receipt.

   In signing this authorization and agreement, it is clearly understood that the fees of this office are set by this office and are not bound by any insurance company's fee schedule. The patient and /or responsible party authorizes Grove Endodontics, P.A. to furnish to their insurance company all information which may be requested. They acknowledge full responsibility for payment of this account and understand that any financial benefits allowed by their insurance company are solely a matter between the insurance company and themselves. They further acknowledge it is not the responsibility of Grove Endodontics, P.A. to verify any such benefits which may be allowed. They will make payment with the understanding they will be reimbursed in the event of an overpayment.

All accounts over 60 days will be turned over to a collection agency unless other payment arrangements have been made. If untimely payments are received while the account is in collections, the patient and/or responsible party will be held liable for any and all finance charges, late payment fees and/or collection agency fees.

There will be a $30 fee for any returned checks. There will be a $27 administrative fee for any patient turned over to collections.

AUTHORIZATION AND AGREEMENT:

____

Name of patient (or responsible party if patient is a minor) please print clearly

___________________________ ___________________

Signature of patient or responsible party *Date*

AUGUST 2008

I have received a copy of this office's privacy practices notice:

____

Patient Signature