

# Dr. Ericka Klein

## PATIENT INFORMATION

Name \_\_\_\_\_ M \_\_\_ F \_\_\_ Married \_\_\_ Single \_\_\_ child \_\_\_  
Address \_\_\_\_\_ Birth date \_\_\_\_\_  
\_\_\_\_\_ SS# \_\_\_\_\_  
Phone # \_\_\_\_\_ Work \_\_\_\_\_ ext \_\_\_\_\_  
E-Mail # \_\_\_\_\_

## EMPLOYMENT INFORMATION OF INSURED

Employer Name \_\_\_\_\_ 2ND Employer Name \_\_\_\_\_  
Address \_\_\_\_\_ Address \_\_\_\_\_  
Phone \_\_\_\_\_ Phone \_\_\_\_\_  
Occupation \_\_\_\_\_ Occupation \_\_\_\_\_

## INSURANCE INFORMATION

Ins co \_\_\_\_\_ insured's info  
Address \_\_\_\_\_ Name \_\_\_\_\_  
\_\_\_\_\_ Birth date \_\_\_\_\_  
Phone # \_\_\_\_\_ SS# \_\_\_\_\_  
Group # \_\_\_\_\_ ID# \_\_\_\_\_  
Relationship to pt \_\_\_\_\_

## SECONDARY INSURANCE INFORMATION

Ins co \_\_\_\_\_ insured's info  
Address \_\_\_\_\_ Name \_\_\_\_\_  
\_\_\_\_\_ Birth date \_\_\_\_\_  
Phone # \_\_\_\_\_ SS# \_\_\_\_\_  
Group # \_\_\_\_\_ ID# \_\_\_\_\_  
Relationship to pt \_\_\_\_\_

## CONSENT TO SERVICES

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon payment from the patients for the cost incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangement, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the insurance claims and help assist in making collections from the insurance company. This office does not render treatment of the assumption that our charges will be paid our patients insurance company.

In consideration for the professional services rendered to me, or at my request, by the doctor or his staff, I agree to pay therefore the reasonable value of said services to said doctor, or its assignee at the time said services are rendered, or within 5 days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be billed unless objected to, by me, in writing within the time of payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

A service charge of 1 1/2 % per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days. Unless previously written financial arrangements are satisfied.

I grant my permission to you or your assignee, to telephone my at home or at my work to discuss matters related to this form.

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

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

Who may we thank for referring you to our office: \_\_\_\_\_