MCCANN-CARPENTER DENTAL CLINIC L.L.C.

PATIENT NAME	NAME PREFERENCE	BIRTHDATE
ADDRESS	CITY	STATE / ZIP
PHONE #	SOCIAL SECURITY #	PREVIOUS DENTIST AND ADDRESS

FATHERS NAME	BIRTHDATE
ADDRESS	CITY / STATE / ZIP
CELLULAR PHONE # / DRIVERS LICENSE #	SOCIAL SECURITY # / E-MAIL ADDRESS
EMPLOYER	WORK PHONE # / JOB TITLE
EMPLOYERS ADDRESS	CITY / STATE / ZIP

MOTHERS NAME	BIRTHDATE
ADDRESS	CITY / STATE / ZIP
CELLULAR PHONE # / DRIVERS LICENSE #	SOCIAL SECURITY # / E-MAIL ADDRESS
EMPLOYER	WORK PHONE # / JOB TITLE
EMPLOYER ADDRESS	CITY / STATE / ZIP

DENTAL INSURANCE COMPANY NAME	POLICY HOLDERS NAME
INSURANCE MAILING ADDRESS	CITY / STATE / ZIP
POLICY # / GROUP #	EMPLOYER PLAN #

CONCERNING INSURANCE

1. Patients who carry dental insurance should remember that professional services are rendered and charged to the patient, not to the insurance company. We will be happy to assist you by filing your claim.
2. Although we may file your claim as a service to you, this office cannot accept responsibility for collection from your insurance or negotiating a settlement on a disputed claim. **You are responsible for payment of your account.**

AUTHORIZATIONS

1. I am responsible for payment of this account in full at the time services are rendered unless previous arrangements have been made.
2. I hereby authorize the release of information to my insurance carrier that may be necessary to process my claim.
3. I hereby authorize the release of any medical records from my physician that are deemed necessary for my dental treatment.
4. I hereby authorize payment directly to this office for the dental expense otherwise payable to me.
5. I understand there will be a rebilling charge of 18% per annum added on any balance over 30 days.
6. I consent to the taking of photographs and x-rays before, during, and after treatment, and to the use of same by the doctor in scientific papers or demonstrations.
7. This authorization pertains to all services incurred hereafter.

SIGNATURE _____ DATE _____