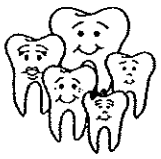

Murphy's Corner DENTAL

PATIENT INFORMATION

Name _____ Preferred Nickname _____

If patient is a child, give name of Parent or Legal Guardian _____ Birthdate _____

Address _____ S.S. # _____

City _____ State _____ Zip _____

Home Phone ( ) _____ Work Phone ( ) _____

Cell Phone ( ) _____ Email Address _____

Occupation _____ Employer _____

Employer Address _____ Is it okay to call you at work? _____

Whom may we thank for the referral? _____

DENTAL INSURANCE

Primary Insurance Company _____

Address _____

Subscriber Name _____ S.S. # _____ Group # _____

Subscriber Birthdate _____ Employer _____

Secondary Insurance Company _____

Address _____

Subscriber Name _____ S.S. # _____ Group # _____

Subscriber Birthdate _____ Employer _____

FINANCIAL AGREEMENT

Please read carefully: initial next to each line.

_____ I the undersigned, agree to accept financial responsibility for any and all dental treatment incurred, regardless of insurance Coverage.

_____ I agree to pay finance charges on any outstanding balance over 30 days. I understand that these charges are assessed at 1 1/2% per month (annual rate of 18%).

_____ In the event of default, I further agree to pay collection and court costs as well as attorney fees incurred in any collection proceedings.

_____ I understand I will be charged for any missed appointments without 24 hour advance rescheduling notice. This charge will be $50.00.

_____ I understand that my insurance will be billed directly; however I accept the responsibility for their processing my claims in a timely manner. If payment is not received within 30 days of the date of treatment, I will pay the responsibility and be reimbursed upon receipt of insurance dollars.

_____ I understand that I will be responsible for my estimated portion at each appointment.

SIGNATURE _____ DATE _____

If for a child, financially responsible adult must sign