

Patient Information (Confidential)

Name: _____ Date: _____
Address: _____
City: _____ State: _____ Zip: _____
Email: _____ Social Security: _____ Birth Date: _____
Home Phone: _____ Cell Phone: _____
Please check appropriate box: Minor Single Married Divorced Widowed
Person to contact in case of an emergency: Name _____
Phone _____
Whom may we thank for referring you? _____

Insurance Information

Name of Insured: _____ Birth Date: _____
Social Security: _____ Relationship to Patient: _____
Name of Employer: _____ Work Phone: _____
Name of Insurance: _____ Ins. Co. Phone: _____
Group #: _____ Policy ID #: _____
Do you have secondary insurance? If yes, please list below.

Insurance Authorization and Account Agreement

As a courtesy to our patients, we complete and file insurance forms. It is your responsibility to provide insurance forms, which are completely filled out and signed with benefits assigned to our office. This office does not determine the benefits under your insurance policy. If you have specific questions, please contact your insurance carrier or employer.

I hereby authorize Thomas A.J. Olivero, Jr., DDS, PLC to furnish information to insurance carriers concerning my treatment and I hereby assign to Thomas A.J. Olivero, Jr., DDS, PLC all payments for services rendered to me or my dependents. I understand that I am responsible for any amount due to Thomas A.J. Olivero, Jr., DDS, PLC not covered by insurance. If my insurance company fails to pay my claim, payment is my responsibility.

I agree to be responsible for my account. In the event that my account is not paid within 60 days from the date of service and my account is referred to an attorney for collection, I will be responsible for all of collection fees and costs, including attorney's fee of 33 1/3 of the unpaid balance and any court costs expended.

Accounts that are not paid in full within 60 days from the date of service will accrue interest on the unpaid balance at a rate of 1.5% per month on the unpaid balance.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN

DATE