PEDIATRIC DENTISTRY

Skip Tyson, D.D.S.
Stephanie Heaney, D.D.S., P.A.

INSURANCE INFORMATION

Is the patient covered by dental insurance: Yes_____No_____

Please complete the following:

Guarantor Information

Responsible Party's Name_____
Home Phone_____Work Phone_____
Mailing Address_____City_____State_____Zip_____
Date of Birth_____Social Security #_____

Primary Carrier

Subscriber's Full Name_____
Subscriber Number_____
Group Plan/Policy Number_____
Employer Name_____
Insurance Company_____Phone Number_____
Insurance Mailing Address_____

In order to comply with most insurance companies, we ask that you sign below so that we may keep your signature on file.

I have reviewed the treatment plan. I authorize release of any information relating to this claim.

_____
Signature of patient or parent (If minor)

I hereby authorize payment directly to Dr. Skip Tyson and Dr. Stephanie Heaney of dental insurance benefit otherwise payable to me

_____
Signature of patient or parent (If minor)

Financial Information, Terms and Conditions

As a condition of treatment by this office, the parent or guardian who accompanies the child is responsible for payment of all fees at the time of service. Payment may be by cash, check, Visa, Discover or Mastercard.

For patients who carry dental insurance, this office will accept assignment of insurance benefits. **Any insurance payment not received within 60 days of service will be your responsibility.**

In consideration of the professional services rendered to my child, I agree to accept responsibility for the payment of such services, and I agree to pay all collection fees, court costs, and reasonable attorney fees incurred by my failure to remit for services rendered. Returned checks will have a $25.00 charge added and be subject to prosecution. Balances over 90 days will be subject to small claims court. I grant permission to you, or your assigns, to telephone me at home or at work to discuss matters related to this form. I have read the above conditions of treatment and agree to its consent.

Signed_____Date_____