



**MOHR
& MOHR SMILES**

Sedation, Family, & Cosmetic Dentistry

INSURANCE INFORMATION

Please present your insurance card to the front desk.

Name of Insured: _____ Relationship: _____

Birth Date: _____ Social Security #: _____ Date employed: _____

Employer: _____ Work Phone: _____

Insurance Company: _____ Group #: _____

Insurance Phone #: _____

Do you have any secondary insurance? Yes No If yes, complete the following

Name of Insured: _____ Relationship: _____ Birth Date: _____

Social Security #: _____ Employer: _____ Date employed: _____

Group #: _____ Insurance Company: _____

Insurance Phone #: _____

FINANCES

Payment in full is expected at each appointment. For your convenience, we offer the following methods of payment. Please check the option which you prefer. If you have any questions concerning financial arrangements, it will be our pleasure to assist you. There will be a \$50 charge for appointments not cancelled within a 48 hour time period.

- Cash Personal Check
 VISA MASTERCARD DISCOVER
 American Express Care Credit

Card # _____

Exp. Date _____

Authorization, Release, & Agreement to Pay for Services Rendered

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such Dental care to third party payors and/or health practitioners.

I authorize and hereby request my insurance company to pay directly to the dentist (or the dental group) insurance benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents.

I agree to pay for all professional fees and treatment. I further agree to pay any collection and legal fees on any balance over 45 days old, should this be a necessary means for collection.

Signature of patient or parent if minor

Date