

SCHNEIDER FAMILY DENTISTRY, S.C.

190 Gardner Ave. Suite 5
Burlington, WI 53105
Tel. (262) 763-6921

*WE WOULD LIKE TO GET
TO KNOW YOU BETTER!*

NAME _____

RESIDENCE _____

ZIP _____

HOME PHONE _____

DATE OF BIRTH _____

DRIVER'S LIC. # _____

SOCIAL SECURITY # _____

E-MAIL ADDRESS _____

IF STUDENT, NAME OF SCHOOL/COLLEGE

OCCUPATION _____

EMPLOYER _____

EMPLOYER'S ADDRESS _____

ZIP _____

EMPLOYER'S PHONE _____

SPOUSE'S OCCUPATION _____

SPOUSE'S EMPLOYER _____

EMPLOYER'S ADDRESS _____

ZIP _____

EMPLOYER'S PHONE _____

WHOM MAY WE SEND A THANK YOU FOR YOUR
REFERRAL

PERSON RESPONSIBLE FOR DENTAL INVESTMENT

FINANCIAL ARRANGEMENTS -

For your convenience, we offer the following methods of payment.
Please check the option you prefer. Payment in full at each
appointment.

Cash Dentamed

Personal Check

Credit Card Visa Mastercard

DATE _____

FOR INSURANCE PURPOSES:

NAME OF PRIMARY CARRIER:

INSURED _____

INSURED'S BIRTHDATE _____

INSURED ID # _____

GROUP/POLICY # _____

EFFECTIVE DATE _____

NAME OF SECONDARY CARRIER:

INSURED _____

INSURED'S BIRTHDATE _____

INSURED ID # _____

GROUP/POLICY # _____

EFFECTIVE DATE _____

LATE CHARGES -

If I do not pay the entire new balance within 25 days of the monthly
billing date, a late charge of 1% on the balance then unpaid and owed
will be assessed each month (if allowed by law). I realize that failure
to keep this account current may result in you being unable to provide
additional services except for emergencies or where there is prepay-
ment for additional services. In the case of default on payment of this
account, I agree to pay collection costs and reasonable attorney fees
incurred in attempting to collect on this amount or any future out-
standing account balances.

AUTHORIZATION AND RELEASE -

I certify that I have read and understand the above information to the
best of my knowledge. The above questions have been accurately
answered. I understand that providing incorrect information can be
dangerous to my health. I authorize the doctor to release any infor-
mation including the diagnosis and the records of any treatment or
examination rendered to me or my child during the period of such
health care to third party payors and/or health practitioners. I autho-
rize and request my insurance company to pay directly to the doctor
or medical group insurance benefits otherwise payable to me. I
understand that my insurance carrier may pay less than the actual bill
for services. I agree to be responsible for payment of all services ren-
dered on my behalf or my dependents.

X

Signature of patient (or parent if minor)

