

Stephen A. Mabry, DDS, PLC

Section I – Information on Patient

Referred by _____

Patient's Name: Mr/Mrs/Ms/Miss/Dr _____, _____, _____ : _____
Circle One (Last) (First) (MI) Name Preferred to Be Called

Address: _____
Street City State Zip Code

Home Phone () _____ Work Phone () _____ Cell Phone() _____ E-Mail Address _____

Social Security Number _____ - _____ - _____ Date of Birth ____/____/____ Sex: M/F If Married Spouse's Name _____
(mm/dd/yyyy) (circle)

Employer _____ Occupation _____

Emergency Contact _____ Relation to Patient _____

Home Phone () _____ Work Phone() _____ Cell Phone() _____ E-Mail Address _____

1. Is the patient covered by dental insurance? _____. If "YES" is patient the insured person? _____

2. Who is responsible for payment of fees not covered by insurance? _____

Section II – Information on Insured Person PLEASE PRESENT INSURANCE CARD

Name of Insured: Mr/Mrs/Ms/Miss/Dr _____, _____, _____
Circle One (Last) (First) (MI)

Social Security Number _____ - _____ - _____ Date of Birth ____/____/____ Sex: M/F _____
(mm/dd/yyyy)

Employer _____ Insurance Co Name _____ ID# _____ Group # _____
(Subscriber/Policy #)

Street _____ City _____ State _____ ZIP _____ Phone _____
(Insurance Company's Address)

The above information is correct, and I will notify Dr. Mabry's office of any changes with my insurance, health, address, phone numbers, etc. I understand the importance of answering the health questions, accurately, and I authorize Dr. Mabry to release any information including diagnosis and records of any treatment for my dependents or for me to third party payers (such as insurance companies) and/or health practitioners.

I understand that, as a service, the office will submit my insurance claim forms, but that I am responsible for all fees not paid by insurance. I understand that my dental insurance company may pay less than the actual fees charged, and that if Dr. Mabry has not received payment from my insurance company within 90 days of submission, I may be responsible for the full balance due. I further agree to be responsible for payment of all services for my dependents and for me. I also understand that I am responsible for all fees not paid by insurance. I agree that if this account becomes delinquent and is placed in the hands of an attorney for collection, I will pay, as a collection fee, an amount equal to one-third of the unpaid principal plus interest accrued and billing charges accrued. I also agree to pay any court costs. Interest will accrue on the balance due at a rate of one and one-half percent per month which is an Annual Percentage Rate of 18.00%. Billing charges will accrue at a rate of \$15.00 per month. Both will begin accruing 90 days after the monies have become due unless waived at Dr. Mabry's written discretion. I further agree to pay returned check charges of \$25.00 per returned check. Additionally, I understand and agree that the terms herein are reaffirmed each time services are received by me or my dependents. I authorize and request my insurance company to pay benefits directly to Dr. Mabry otherwise payable to me.

Signature of Patient/ Responsible Party _____ Date _____