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. Two(2) attempts will be made to submit insurance claims. I authorize and request my insurance company to pay benefits directly to Dr. Mabry otherwise payable to me. 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 $35.00 per returned check. Additionally, I understand and agree that the terms herein are reaffirmed each time services are received by me or my dependents
**A $75 cancellation fee applies to appointments cancelled with less than 48 hrs notice. **

Signature of Patient/ Responsible Party___________________________________ Date_________________

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