Date _____

FINANCIAL INFORMATION

PATIENTS: _____ _____ _____

_____ _____ _____

_____ _____ _____

Father's Name _____

□ Single □ Married □ Divorced

Address (if different) _____

_____

Home Phone_____

Cell Phone _____

Work Phone _____

Employer _____

Soc. Sec.# _____Birthdate_____

Do you have dental insurance coverage for child? □Yes □ No

Plan Name _____

Ins. Phone No. _____

Address _____

_____

Group # _____

Policy/ID #_____

Mother's Name _____

□ Single □ Married □ Divorced

Address (if different) _____

_____

Home Phone_____

Cell Phone _____

Work Phone _____

Employer _____

Soc. Sec. #_____Birthdate_____

Do you have dental insurance coverage for child? □Yes □ No

Plan Name _____

Ins. Phone No. _____

Address _____

_____

Group # _____

Policy/ID # _____

I understand that I am financially responsible for all charges whether or not paid by insurance and agree to reimburse Hilgers Pediatric Dentistry the fees of any collection agency, which may be based on a percentage at a maximum of 50% of the debt, and all costs, and expenses, including reasonable attorneys' fees Hilgers Pediatric Dentistry incurs in such collection efforts.

Parent/Guardian Signature _____ Date _____

<u>If you have insurance</u>, please fill out the following statement:

I certify that my minor/child is covered by insurance with _____

Name of Insurance Company

and assign directly to Dr. Kelly Hilgers/Hilgers Pediatric Dentistry all insurance benefits, if any, otherwise payable to me for services rendered. I have been informed whether my insurance is in or out of network. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic. I have received a copy of the practice's Financial Policy.

Parent/Guardian Signature _____ Date _____