Joseph A. Maloney D.D.S.
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Family and Cosmetic Dentistry

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PATIENT INFORMATION

DATE_____

NAME _____ BIRTHDATE _____ SEX ____
FIRST MI LAST

ADDRESS _____ SS#_____

CITY_____ STATE____ ZIP_____ □SINGLE □MARRIED □DIVORCED

PHONE _____ DRIVER'S LIC. #_____
HOME WORK CELL

EMPLOYER_____
NAME ADDRESS

PERSON TO CONTACT IN CASE OF EMERGENCY _____
NAME PHONE

Has any member of your family ever been treated in our office? □Yes □No

Whom may we thank for referring you to our office? _____

INSURANCE INFORMATION

PERSON RESPONSIBLE FOR ACCT □SELF □SPOUSE □FATHER □MOTHER □GUARDIAN

PRIMARY	SECONDARY
INSURANCE CO._____	INSURANCE CO._____
GROUP #_____	GROUP #_____
INS. CO. ADDRESS_____	INS. CO. ADDRESS_____
NAME OF INSURED_____	NAME OF INSURED_____
BIRTHDATE OF INSURED_____	BIRTHDATE OF INSURED_____
SS# OF INSURED_____	SS# OF INSURED_____
EMPLOYER_____	EMPLOYER_____
WORK NUMBER_____	WORK NUMBER_____

I understand that my dental insurance is a contract between the insurance carrier and me and not between the insurance carrier and the dentist; therefore, I am still responsible for all dental fees. I understand that I will be charged for all dental treatment and that any payments received by the Dental Office from my insurance coverage will be credited to my account or refunded to me if I have paid the dental fees incurred.

BROKEN APPOINTMENTS

I will be responsible for giving the dental office at least 24 hours notice if I cannot keep a previously scheduled appointment. If I do not provide the dental office with 24 hours notice, I will be responsible for a broken appointment charge of $10 per 15 minutes of appointment time.

FINANCE CHARGES

If I do not pay the entire new balance within 60 days of the monthly billing date, a finance charge will be added to the account for the current monthly billing period. The finance charge will be a periodic rate of 1% per month (or a minimum charge of $2 for a balance under $200) which is an annual percentage rate of 12.69% applied to the last month's balance. In case of default payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts. A service charge of $25 will also apply to any bounced check that is received.

PAYMENT

I understand that payment in full is expected at time of service unless prior financial arrangements have been made with the Dental Office.

AUTHORIZATION

I hereby authorize payment directly to the Dental Office of the insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals.

X _____
Signature Date