GENERAL INFORMATION

This information is requested for financial and credit purposes.
FATHER (full name) _____
Address _____ City _____ ST _____ Zip _____
Hm Phone ( ) _____ SS # ____ - ___ - _____ Birth date _____ Marital Status _____
Employer _____ Wrk Phone ( ) _____ Cell ( ) _____
E-Mail Address _____ Drivers License Number _____

MOTHER (full name) _____
Address _____ City _____ ST _____ Zip _____
Hm Phone ( ) _____ SS# ____ - ___ - _____ Birth date _____ Marital Status _____
Employer _____ Wrk Phone ( ) _____ Cell ( ) _____
E-Mail Address _____ Drivers License Number _____
Name of nearest relative _____ Hm ( ) _____ Wrk ( ) _____
Relation to which parent and relation to patient _____

INSURANCE INFORMATION ---- PLEASE PROVIDE ACCURATE INFORMATION

PRIMARY DENTAL INSURANCE

Name of subscriber _____ Subscribers ID _____ Grp No. _____
Name of Insurance Co. _____ Phone No. _____
Address _____ City _____ ST _____ Zip_____
Policy holders employer _____

SECONDARY DENTAL INSURANCE

Name of subscriber _____ Subscribers ID _____ Grp No. _____
Name of Insurance Co. _____ Phone No. _____
Address _____ City _____ ST _____ Zip_____
Policy holders employer _____

MEDICAID/IDAHO SMILES _____ YES _____ NO

Assignment of Benefits: _____ (Signature of responsible party) I authorize Dr. Mauseth to furnish my insurance company with all information to process my dental claims. I authorize the above named insurance company to pay all benefits due me directly to Dr. Mauseth. I understand I am responsible for charges not covered by this assignment. In the event I do not provide accurate insurance information I will be billed a $50 administrative re-processing fee to file insurances correctly.

FINANCIAL AGREEMENT

Our financial policy is to receive payment in full by the time treatment is completed. If this is not convenient for you, we do accept VISA and MasterCard, and can direct you to other sources of credit. If you have dental insurance, your estimated co-payment will be required at the time of service. You will be billed for any remaining balance that is not paid by your insurance. Interest, at the annual rate of 18% (compounded monthly), will be added to any balance over 60 days, starting from the date the charge was made. Any account over 90 days delinquent will be turned over to a collection agency. If this account is assigned to an outside agency for collection I/we agree to pay all attorney fees, court costs, process service fees, filing fees, and any charges or commissions, up to 50%, that may be assessed by any collection agency retained to pursue this matter.

SIGNATURE_____ **RELATIONSHIP TO CHILD** _____
DATE _____