



FINANCIAL INFORMATION

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www.theclassicsmile.com

PERSONAL INFORMATION

Name (Last, First, Middle):		Date of Birth: / /	
Home Address:			
City:	State:	Zip:	
Home Phone:		Business Phone:	
Social Security Number: - - -	Place of Employ or School	Address of Employ	
Person Responsible for Account	Telephone #	Relationship:	

PRIMARY

INSURANCE INFORMATION

(Person with the dental plan)

SECONDARY
(Request second form)

Name of Insured person:		Relationship:	
SS#: - - -	Address (if different)	Group #	Subscriber #
Name of company employed at:		Name of Dental Insurance:	
Address Of Company	City	Yearly Max	Deductible Aniv. Date

I give THE CLASSIC SMILE permission to release information to my Insurance company: YES () NO ()

Method Of Payment Cash or Check Credit Card Financial Arrangements

HIPAA form presented? YES () NO ()

*INITIAL IN EACH BOX

Finance charge: if my balance is not paid within 30 days of a treatment, a late fee will be charged at a periodic rate of 1.5% per month (or a minimum charge of \$2 for a balance under \$134) which is an annual percentage rate of 18% applied to the last months balance.

In case of default of payment, I agree to pay any legal interest on the balance due, together with any collection on this account.

AUTHORIZATION: I hereby authorize payment, directly to the dental office, of the group insurance benefits otherwise payable to me.

I understand that I am responsible for all costs of dental treatment including a charge, equal to the amount of the scheduled appt. for appointments that are broken without 48 hours notice.

I hereby authorize the dental office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care.

The information on this page and the medical history supplied by me to this office are correct to the best of my knowledge. I have read the above policy and agree with its terms.

Signature Of Responsible Party _____ Date / /