

Date: _____

Patient Name: _____

Treatment Plan Total \$ _____

I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my personal health information to carry out payment activities in conjunction with this claim.

Patient/Guardian Signature Date \$ _____
Agreement Total

Terms of Payment:

Yes No
 Cash or Check _____ \$ _____
Check number

Payment Summary

Appointment Reservation \$ _____
At Initial Treatment _____ \$ _____
Date

Payment will be made via (Electronic Draft) of Credit, Debit, Medical Savings, etc.:
Name as it appears on Card: _____
Card Type _____ Last 4 Digits _____ Exp. Date: ____/____

Convenient Payment Plan (see attached form).

I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

Based upon the information provided by me, I understand that my benefit plan is anticipated to reimburse \$_____ for this series of visits. If by _____ my benefit plan has not paid this amount,
Date
I authorize the above referenced account be used to satisfy any remaining unpaid balance.

Remaining Balance due by _____ \$ _____
Date

Total amount paid \$ _____

I agree to the above payment terms.

Patient/Guardian Signature Date

Financial Coordinator Signature Date

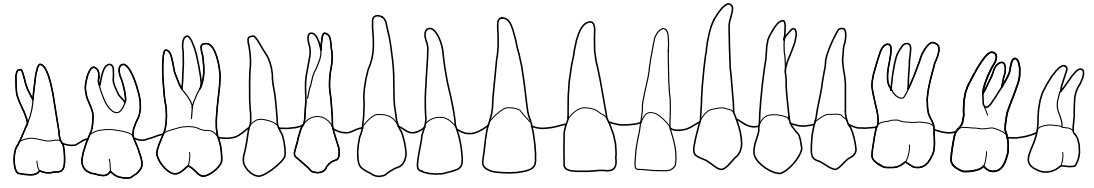
Closing Date: / /

File Number: _____

File Number: _____

Closing Date: / /

Facial

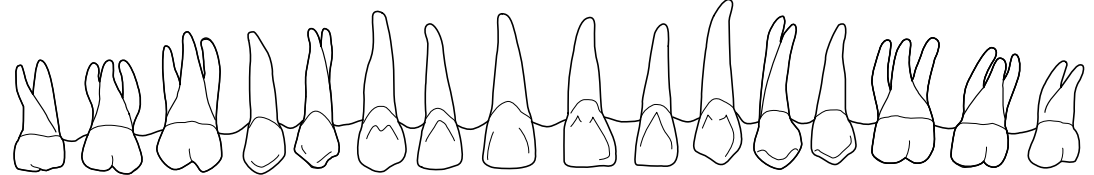


R



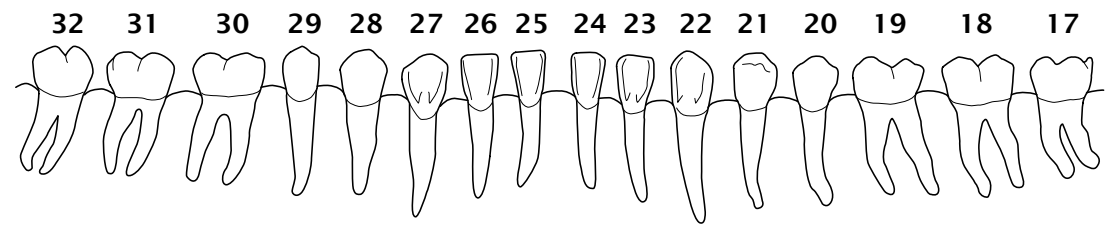
L

Lingual



1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

Lingual



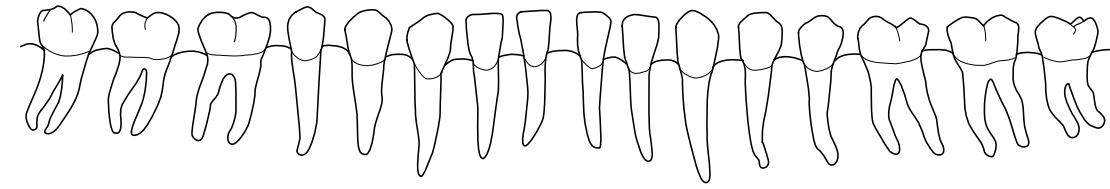
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

R



L

Facial



Treatment Plan Total:
