Pham, 307 Maple Ave West, Suite M Biga & Vienna, Va 22180 Maloney, PLLC (703) 281-1090

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NAME	BIRTHDATE SEX □M □F
ADDRESS	
CITY STATE	
PHONE WORK CELL	DRIVER'S LIC. #
HOME WORK CELL EMAIL Wo	
Would you like to have appointments confirmed by: □ Email	I □ Home # □ Work # □ Cell #
INSURANCE INFORMATION	
PRIMARY INSURANCE CO	SECONDARY INSURANCE CO
GROUP NAME	GROUP NAME
GROUP #	GROUP #
INS. CO. PHONE	INS. CO. PHONE
SUBSCRIBER NAME	SUBSCRIBER NAME
SUBSCRIBER BIRTHDATE	SUBSCRIBER BIRTHDATE
SUBSCRIBER ID#	SUBSCRIBER ID#
EMPLOYER	EMPLOYER

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.

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 bank service charge 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 payers and/or other health professionals.

X			
	Signature	Date	