JERRY BRADLEY DDS & ASSOCIATES, PLLC
CONSENT FORM

SPOUSE OR RESPONSIBLE PARTY INFORMATION

The following is for: __ the patient's spouse __ the person responsible for payment
Name: ____________________
__Male __Female __Married __Single __Child __Other
Social Security #: ____________________ Birth Date: ____________________
Phone (Home): __________ (Work) __________ Ext: __________ Best time to call: ____________________
Address: ____________________
Street Apt. #
____
City State Zip Code

EMPLOYMENT INFORMATION

The following is for: __the patient __the person responsible for payment
Employer Name: ____________________ Occupation: ____________________
Address: ____________________
Street City State Zip Code

PRIMARY INSURANCE INFORMATION

Name of Insured: ____________________ Is Insured a patient? __yes __no
Last First MI
Insured's Birth Date: __________ ID#: __________ Group #: __________
Insured's Address: ____________________
Street City State Zip Code
Insured's Employer Name: ____________________
Address: ____________________
Street City State Zip Code
Patient's relationship to insured: __Self __Spouse __Child __Other __________
Insurance Plan Name and Address: ____________________

SECONDARY INSURANCE INFORMATION

Name if Insured ____________________Is insured a patient? __yes ___no
Insured's Birth Date: __________ ID #: __________ Group # __________
Insured's Address: ____________________
Street City State Zip Code
Insured's Employer Name: ____________________
Address: ____________________
Street City State Zip Code
Patient's relationship to insured: __Self __Spouse __Child __Other __________
Insurance Plan Name Address: ____________________

CONSENT FOR SERVICES

As a condition of your treatment by this office, financial arrangements must be made. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time serviced are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1 ½ % per month on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that a fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

I have read and understand the above information and conditions of treatment and payment. I authorize the dentist to release any information and conditions of treatment and payment. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist, insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for service. I agree to be responsible of all services rendered to me or my dependents.

____________________ **Date:** __________ **Relationship to Patient:** ____________________
Signature of patient, parent or guardian

____________________ **Date:** __________ **Relationship to Patient:** ____________________
Signature of guarantor of payment/responsible part