Danville Dental Group, PLC

31 Mountain View Dr ~ Danville, VT 05828

Child Registration & Payment Agreement

Name of Child:_____
Date of Birth: ___/___/_____ Male or Female SS#_____-_____-_____
Home Phone:_____
Mailing Address:_____

Person Responsible for Bill:
Name:_____
Address:_____
Home Phone:_____ Cell Phone:_____
Work Phone:_____ E-Mail_____
Relationship to Child:_____

Father/Guardian Name:_____
Address:_____
Home Phone:_____ Cell Phone:_____
Work Phone:_____ E-Mail:_____

Mother/Guardian Name:_____
Address:_____
Home Phone:_____ Cell Phone:_____
Work Phone:_____ E-Mail:_____

Dental Insurance:_____
Subscriber Name:_____ Relation to Patient:_____
Social Security or ID of Subscriber:_____ Group#:_____
Subscriber Date of Birth: ___/___/_____ Insurance Phone #:_____
Employer Name & Address:_____
Insurance Company Name & Address:_____
_____

I agree to pay all charges for dental services provided by this office to me and my family within 30 days from the date of service. I understand that balances over 30 days will be charged a 1% per month or a minimum billing charge of $3.00 per month. This is equivalent to an APR of 12.7% or a minimal billing fee of $36.00 per year. I hereby authorize payment directly to Danville Dental Group, PLC of any dental benefits payable to me as a result of services performed by this office. I authorize the release of any information by Danville Dental Group, PLC as required by my dental insurance program for settlement of claims. In the event that this account is placed with an attorney or other agent for collection, I agree to pay reasonable attorney fees, and other costs and fees of collection.

Responsible Party Signature:_____ Date:_____