Danville Dental Group, PLC

31 Mountain View Dr. ~ Danville, VT 05828

Registration & Payment Agreement

Patient Name:_____
Date of Birth: ___/___/_____ Male or Female Social Security # _____-____-_____
Marital Status: Single Married Divorced Widowed
Home Phone:_____ Cell Phone:_____
Work Phone:_____ E-Mail_____
Mailing Address:_____
Employer Name & Address:_____
In Case of Emergency Contact:_____

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

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

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.

Patient Signature:_____ Date:_____
Responsible Party Signature:_____ Date:_____