Name of Primary Dental Insurance Plan

Policy or Group # Subscribers Name (if different) SSN of Subscriber

Name of Secondary Dental Insurance Plan

Policy or Group # Subscribers Name (if different) SSN of Subscriber

There will be a charge for broken appointments without 24 hours notice. I understand that responsibility for payment for dental services provided in this office for myself or my dependent is mine, regardless of insurance benefits. I also understand that payment is due and payable at the time services are rendered. A finance charge will be added, if payment is not received within 90 days of service. I realize that failure to keep this account current may result in you being unable to provide additional dental services. unaa4rma179.9Si

Signature Date / /