



FINANCIAL INFORMATION AND POLICIES

Person responsible for this account _____
Marital status: Married Single
Address _____
Drivers License Number _____ Phone Number _____

Is patient covered by dental insurance? Yes or No

Insurance Company Name _____
Address _____ City/State/Zip _____
Telephone # _____
Whose name is the policy under? _____ Group # _____
Date of Birth _____ Social Security # _____
Employer Name _____ Employer Phone # _____

Is patient covered by secondary insurance? Yes or No

Insurance Company Name _____
Address _____ City/State/Zip _____
Telephone # _____
Whose name is the policy under? _____ Group # _____
Date of Birth _____ Social Security # _____
Employer Name _____ Employer Phone # _____

DENTAL INSURANCE is a contract between a patient/guardian and the insurance company and in no way absolves the patient/guardian of full responsibility for the charges incurred. Estimates of insurance payment made by this office are considered a guideline only. We can make no guarantee of the insurance payment(s) estimated. We are pleased to help process insurance forms, help maximize your insurance benefits and are glad to help answer any questions you may have about your treatment or treatment estimates. I hereby authorize payment directly to Gateway Dental of the group insurance benefits otherwise payable to me.

SCHEDULED APPOINTMENTS: The time scheduled for your visit is set aside especially for you. We look forward to making your visit pleasant, comfortable and productive. In the unlikely event you are unable to make your appointment, we ask that you give us 24 hours notice so that we may give this time to other patients needing treatment. There will be a \$35 charge for appointment(s) missed or broken without 24 hours notice.

FINANCE CHARGES: A monthly charge of 1.5% (18% annually) will be added to all account balances not paid within 60 days of services. A late fee of \$10/month will be assessed to all past due accounts.

I have read, understand and agree to the above policies. In the event of default, I agree to pay all costs of collection as well as court costs and reasonable attorney's fees in the event legal action is taken.

Patient or Guardian Signature _____ date _____

Witness Signature _____ date _____

DR. ROBERT S. SALMANS, DDS

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