HORSEHEADS DENTAL

Helping People Help Themselves
Through Prevention and Education

2898 Westinghouse Road, Suite 524
Horseheads, NY 14845
(607) 739-3528
www.HorseheadsDental.com

ACCOUNT INFORMATION

Name of person responsible for payment____Relationship to patient___________
Last First Middle

Mailing address____(___)______________
Street City State ZIP Phone

Employer____Occupation_____________________SS#_________________________

Business address____(___)______________
Street City State ZIP Phone

Primary dental insurance carrier company____

Employee____ Group#____

Birthdate_________________________________SS#_________________________________

Employer____

Business address____(___)______________
Street City State ZIP Phone

Secondary dental insurance carrier company____

Employee____ Group#____

Birthdate_________________________________SS#_________________________________

Employer____

Business address____(___)______________
Street City State ZIP Phone

METHOD OF PAYMENT

All charges of $______________ or less are to be paid in full at time of service (cash, personal check, MasterCard, Visa).

□ I wish to pay in full at each visit (cash, check or credit card).

□ I wish to discuss the office’s financial policy.

SERVICE CHARGE

If I do not pay the entire new balance within 30 days of the monthly billing date, a service charge will be added to the account for the current monthly billing period.

The service charge will be a periodic rate of 1.5% per month, which is an annual percentage rate of 18% unless involved with a financial arrangement, in which the finance charge will be waived.

ACKNOWLEDGMENT

I understand that I am responsible for all costs of dental treatment. I hereby authorize Warren E. Eng, D.D.S., F.A.G.D. to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care.

The information on this page is correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third-party payers and/or other health professionals.

____ __________________

Signature of: □ Adult patient □ Father □ Mother □ Spouse □ Partner □ Guardian Date