8131-J Ritchie Highway
Pasadena, MD 21122
410-64-SMILE (76453)
BarkerSmiles@gmail.com

Patient Information

First Name: ___________________________________ Last Name: __________________________________

Middle Initial: ___________ Preferred Name: _______________________________________ Sex: M F

Birth Date: _____________________________ Social Security #: ___________________________________

Address:____

City: ___________________________________ State: ___________________ Zip: _____________________

Home Phone: __________________________________ Cell Phone: _________________________________

E-mail: ____

Insurance Information

Dental Insurance Company: ____

Employer: ____

ID Number: __________________________________ Group Number: _______________________________

Policy Holder (if not self): ________________________________Birth Date (if not self): _______________

Authorization and Financial Agreement

I authorize the doctor to release any information including the diagnosis and the records of any treatment or examination rendered to me to third party payers and health practitioners. I authorize and request my insurance company to pay directly to the doctor insurance benefits otherwise payable to me. If for some reason the insurance company has not paid their portion within 45 days from the start of treatment, I am responsible for payment at that time. I understand that I am subject to a $35 per half hour of appointment time when not showing for or canceling an appointment with less than 36 hours' notice. **I understand that payment is due at time of service unless other written arrangements have been made.** All bills are due upon receipt. In the event payments are not received within 30 days, I understand that a 1 ½ % per month carrying charge (18%APR) will be added. There is a billing fee of $8 for bills sent after the first one. If this account is turned over for collection, I agree to pay all reasonable costs of collection including but not limited to attorney fees, court costs and process service.

____ ___________________________

Signature of Patient, Parent/Guardian Date