Maser Dental

30 Orchard Street, Dover, New Jersey 07801

New Patient Registration – Child

PATIENT

Last Name: _____ First Name: _____ MI: _____ DOB: _____

Street: _____ Apt: _____ City: _____ ST: ____ ZIP: _____

We confirm appointments electronically by email. Please provide your email so we may remind you of scheduled appointments.

Email _____ @ _____

PARENT/GUARDIAN

Last Name: _____ First Name: _____ MI: _____ DOB: _____

Street: _____ Apt: ____ City: _____ ST: ____ ZIP:_____ SS#: _____

Home : _____ Cell: _____ Work: _____

Employer: _____ Occupation: _____

Employer Address: _____ City: _____ ST: _____ ZIP: _____

PRIMARY Dental Insurance: _____

Subscriber Name: _____

Relationship to Patient: _____ DOB: _____

Group# _____ SS# _____

ID# _____

SECONDARY Dental Insurance: _____

Subscriber Name: _____

Relationship to Patient: _____ DOB: _____

Group# _____ SS# _____

ID# _____

Financial Policy

As the parent/guardian of this patient, you are responsible for all charges incurred for any treatment rendered regardless of insurance coverage. Payment in full is expected at time of treatment unless prior arrangements have been made. We will file claims to your insurance on your behalf, but any amount not covered by your insurance is your responsibility and payable immediately. If we have received a predetermination of eligibility from your insurance provider, any deductible and/or charges not covered by your insurance and deemed payable by you are expected at the time of your appointment.

We accept payment in cash, check or credit card. Checks returned for insufficient funds will result in a $35.00 returned check fee.

We require 24 hours notice of cancellation for all appointments. We reserve the right to charge a missed appointment fee of $50.00 for the time that was scheduled for you.

Any outstanding balance is due within 30 days of billing. Accounts more than 90 days past due are considered delinquent and will be sent to a collection agencyy. Any account sent to collection will incur a charge equal to 20% of the unpaid balance, which will be added to your account.

Thank you for your cooperation in understanding our financial policy. If you have any questions, please feel free to ask us. We will be happy to help you in any way that we can.

I have read and understand the above financial policy and agree to abide by its terms.

Parent/Guardian

Signature: _____ **Date:** _____

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