PLAINFIELD FAMILY DENTAL, P.C.
Timothy J. Williams D.D.S.

Child's Name _____ Date of Birth _____ Age _____
Address _____City, St., Zip_____
Home Phone _____Cell Phone _____
Father's Name _____ Mother's Name _____

Father's Employer _____ Employer Address _____
City, St., Zip _____Employer Phone _____

Mother's Employer _____ Employer Address _____
City, St., Zip _____Employer Phone _____

Person to be billed _____ Relationship_____
Address _____City, St., Zip_____
Home Phone _____ Cell Phone_____
Social Security #_____ Date of Birth_____

Do you have dental insurance? YES NO
Insurance Company _____ Group #_____
Member's Name _____Employer_____
Member's Social Security #_____Date of Birth_____

Who should we contact in case of an emergency? _____
Address_____ Phone_____
Name of child's physician _____ Phone_____
Who may we thank for referring you to our office? _____

PAYMENT IS EXPECTED AT THE TIME SERVICES ARE RENDERED

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible, co-insurance, or any other balance not paid for by your insurance. A monthly billing charge of $25.00 will be applied to any account having a 90 day balance. I assume and agree to pay all collection agency fees that can be up to an additional 10% of the amount turned over for collection. In the course of collection of the amount due, an attorney may be engaged by this office or the collection agency. I assume and agree to pay attorneys' fees, court costs and other costs paid or incurred by this office or our collection agency while collecting the amount due.

A fee will be charged for appointments cancelled with less than 24 hour notice up to $50.00.

I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize treatment of the person named above.

Signature_____Date_____
Relationship to Child_____