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

Full name_____Date of Birth_____Age_____

Marital status_____Social Security #_____Driver's license #_____

Address_____City, St, Zip_____

Home phone #_____Cell phone #_____email_____

Employer_____Occupation_____

Address_____Phone #_____

Spouse's name_____Employer_____

Employer's address_____Employer phone #_____

Do you have dental insurance coverage? YES NO
Insurance Company_____Group #_____

Member's name_____ID #_____

Who should we contact in case of emergency?Name_____

Address_____Phone #_____

Name of Physician_____Phone #_____

Address_____City, St, Zip_____

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 company. 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 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.

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_____