

Martha Muldowney, D.D.S.

5382 Williams Drive

Roscoe IL 61073

(815)623-9292



## Patient Information

Please take a moment to enter or update your information to help us ensure the quality of your care is excellent.

Chart #.

FOR OFFICE USE ONLY

Patient Name:

Last

First

MI

Preferred Name

Title:  Gender:  Male  Female Family Status:  Married  Single  Child  Other  
Mr/Ms/Mrs/etc

Birth Date:  Prev. Visit:  Email Address:

Phone:     Best time to call:

Home

Work

Ext

Mobile

Address:

City

State

Zip Code

Whom may we thank for referring you to our practice?

- Dental Office  Yellow Pages  Internet  
 Newspaper  School  Work  
 Other (name below):

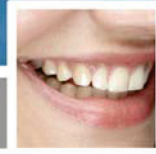
Name of person, office, or other source referring you to our practice:

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## Spouse or Responsible Party Information

The following is for:  the patient's spouse  the person responsible for payment  neither-not applicable

Name:      
Last First MI Preferred Name

Title:  Gender:  Male  Female Family Status:  Married  Single  Child  Other  
Mr/Ms/Mrs/etc

Birth Date:  Email Address:

Phone:     Best time to call:   
Home Work Ext Mobile

Address:    
    
City State Zip Code

## Employment Information

The following is for:  the patient  the person responsible for payment

Employer Name:  Phone:

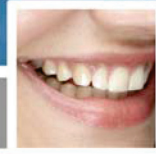
Address:    
    
City State Zip Code

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## Primary Insurance Information

### Primary Dental Insurance:

Name of Insured:     
Last First MI

Insured's Birth Date:  ID #:  Group #:

Insured's Address:    
    
City State Zip Code

Insured's Employer Name:

Employer Address:    
    
City State Zip Code

Patient's relationship to insured:  Self  Spouse  Child  Other

Insurance Plan Name:

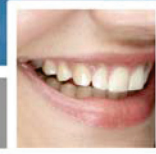
Insurance Address:    
    
City State Zip Code

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## Secondary Insurance Information

### Secondary Dental Insurance:

Name of Insured:     
Last First MI

Insured's Birth Date:  ID #:  Group #:

Insured's Address:    
    
City State Zip Code

Insured's Employer Name:

Employer Address:    
    
City State Zip Code

Patient's relationship to insured:  Self  Spouse  Child  Other

Insurance Plan Name:

Insurance Address:    
    
City State Zip Code

## TERMS AND CONDITIONS

This office depends upon reimbursement from the patient for the costs incurred in their case. The financial responsibility of each patient must be determined before treatment.

As a condition of treatment by this office, I understand financial arrangements must be made in advance. All emergency dental services, or any dental service performed without prior financial arrangements, must be paid for at the time the services are performed. I understand that dental services furnished to me are charged directly to me and that I personally responsible for payment. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However, this dental office cannot render services on the assumption that charges will be paid by an insurance company.

**Assignment of Insurance:** I hereby authorize releases of any information needed and also authorize my insurance company to pay directly to this office benefits accruing to me under my policy. I understand that the fee estimate listed for this dental care can only be extended for a period of 90 days from the date of the patient's examination. I also understand that in order to collect my debt, my credit history may be checked through the use of my Social Security Number or any other information I have given to you. I agree that in the event that either this office or I institute any legal proceeding with respect to amounts owed by me for services rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attorney's fees. I grant my permission to you, or your assignee, to telephone me at home or at my work to discuss matters related to this form. I have read the above conditions and agree to their content.

X

Signed

X

Date

## COLLECTION FEE AGREEMENT

I, the undersigned, hereby agree that in the event of default in the payment of any amount due, and if this account is placed with a collection agency, for collection or subsequent legal action, to pay an additional collection fee of 30% of the account balance due, as well as any attorney fees and court costs incurred and permitted by laws governing these transactions.

X

Signed

X

Date