## STEVEN D. PENDLETON D.D.S., P.A.

www.stevenpendletondds.com

## 9000 State Ave. Kansas City, Kansas 66112 (913) 299-0704

## **ADULT PATIENT INFORMATION**

Name of Patient	Middle	Last	Preferred Nar	me		
M E Age Date of Distr						
M F Age Date of Birth		Single	Married	_ Divorced	Widowed	
Home AddressStreet	City	-		-		
Person Financially Responsible		Pointionabi-	State		Zip Code	
Home Phone #Cell						
Full Time College Student Y N	1 110110 #		Eman			
Name and Address of College/University						
Patient/Parent Name						
Employer		Spouse/Parent Name				
Name Address		EmployerName Address				
Work Phone # Ext DOB_		Work Phone #		Ext D	OB /_ /	
Social Security Number/		Social Security Num				
Do you have dental insurance coverage for patient? Y N Additional insurance coverage? Y N						
	# Group #					
Insurance Co						
Subscriber Name, DOB & SSN						
SECONDARY INSURANCE Insurance ID #						
Insurance Co						
Subscriber Name, DOB & SSN						
		CONTACTS				
2ND Contact						
_	one		Relationship	p to Patient		
3RD Contact						
Name Pho	one		Relationship	to Patient		
In order to contact you,	we will use an	y information you pro	ovide. Thank	you!		
	<u>AUTHORI</u>	ZATIONS				
The information that I have given is correct to the confidence, and it is my responsibility to inform the dental staff to perform the necessary dental assign directly to <b>STEVEN D. PENDLETON D.I</b> rendered. I understand that I am financially response the dentist to release all information necessary all my insurance submissions, whether manual	ne best of my ke this office of a services for m D.S., P.A. all in consible for all to secure the	nowledge. I understa ny changes in my me nyself AND I certify th surance benefits, if a	edical or insunat I am covi any, otherwis	urance statu ered by insu e payable to	s. I authorize rance and I o me for services	
Signature of Patient/Parent/Guardian				/		

## PATIENT FINANCIAL AGREEMENT FORM

Welcome to **Steven D. Pendleton, DDS PA**. Our professional staff is committed to your treatment being successful. The following is a statement of our Financial Policy, which we require you read and sign prior to receiving treatment.

I hereby authorize the release of pertinent medical/dental information to my insurance carriers. I am aware that health insurance coverage varies and, while insurance carriers may use terms such as customary, reasonable, prevailing, etc. to limit their coverage, I am ultimately responsible for payment of all charges for services rendered by the physicians of **Steven D. Pendleton, DDS PA**, and any other charges for laboratory fees, radiology fees, and any other fees as a result of the treatment rendered. If I have insurance that the doctors are contracted with, I understand that I will be responsible for any co-payments, deductibles, co-insurance, or any services that are not considered medically necessary by my insurance company.

I understand and agree that if my payment is by check and the check is returned from the bank unpaid, due to insufficient funds or for other reasons, there will be an additional \$30 fee on top of the total amount the check was written for.

I understand and agree that there will be a late fee of \$10 added to my account if I fail to pay within thirty (30) days from my first statement and an additional \$10 each thirty (30) days thereafter. I understand that I am solely responsible for this late fee and that it will not be billed to my insurance.

In the event that I fail to pay the balance of my account to Steven D. Pendleton, DDS PA within sixty (60) days of the date of service, my account may be reported to an outside collection agency. In the event that it is necessary to turn my account over to a collection agency, I will also be responsible for any and all costs of collection, including attorney fees and interest charges.

I agree that, rather than having my account sent to collection if I fail to pay within sixty (60) days, I would prefer that my account balance be charged to my VISA or MASTERCARD or DISCOVER. This card is only to be charged if I fail to pay my balance within 60 days. Credit Card Using for Payment: MasterCard Visa Discover

Number:	ExpirationDate:		
Signature:		CVV (3 digit security code)	
Authorization & Release I have read and fully understand the Patient Finderstand the Patient Finderstand acres I understand that this Authorization shall apply any other person for which I have assumed resuntil it has been revoked in writing.	eement for ret to all services	ference. s provided to me, my dependents, or	
Patient/Responsible Party Signature	Date	Printed Name	