STEVEN D. PENDLETON D.D.S., P.A. 9000 State Ave. Kansas City, Kansas 66112 (913) 299-0704
www.stevenpendletondds.com

CHILD PATIENT INFORMATION

Name of Child/Minor ______________________ (First / Middle / Last) Preferred Name __________

M____ F____ Age______ Date of Birth ____/____/______ Social Security Number _____-_____-_______

Home Address __________________ (Street / City / State / Zip Code)

Person Financially Responsible ________________ Relationship to Patient ____________

Home Phone # ____________ Cell Phone # ____________ Email ____________

Full Time Student Y____ N_____

Name and Address of School ______________________ Grade ________

Father/Guardian Name ____________ Mother/Guardian Name ____________

Address (if different) ____________ Address (if different) ____________

Employer ____________ (Name / Address) Employer ____________ (Name / Address)

Work Phone # ________ Ext ____ DOB ___/___/___ Work Phone # ________ Ext ____ DOB ___/___/___

Social Security Number _____/_____/______ Social Security Number _____/_____/______

Do you have dental insurance coverage for patient? Y____ N____ Additional insurance coverage? Y____ N____

PRIMARY INSURANCE Insurance ID # ______________ Group # __________

Insurance Co. ____________ Address ____________ Phone # ________

Subscriber Name, DOB & SSN ______________________

SECONDARY INSURANCE Insurance ID # ______________ Group # __________

Insurance Co. ____________ Address ____________ Phone # ________

Subscriber Name, DOB & SSN ______________________

ADDITIONAL CONTACTS

2ND Contact ____________ ____________ ____________
Name Phone Relationship to Patient

3RD Contact ____________ ____________ ____________
Name Phone Relationship to Patient

In order to contact you, we will use any information you provide. Thank you!

AUTHORIZATIONS

The information that I have given is correct to the best of my knowledge. I understand that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my medical or insurance status. I authorize the dental staff to perform the necessary dental services for myself AND I certify that I am covered by insurance and I assign directly to **STEVEN D. PENDLETON D.D.S., P.A.** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electric.

______________________________ ____/______/______
Signature of Patient/Parent/Guardian Date

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 Financial Agreement as outlined above. I have also been given a copy of the Patient Financial Agreement for reference.
I understand that this Authorization shall apply to all services provided to me, my dependents, or any other person for which I have assumed responsibility by signing below, from this date forward until it has been revoked in writing.

________________________________ ________________________________
Patient/Responsible Party Signature   Date   Printed Name