

AUTHORIZATION (IF PATIENT IS A MINOR)

I give my permission to Dr. Van Gorden and/or his designated colleague or assistant to perform any and all dental techniques and procedures, including but not limited to the administration of nitrous oxide sedation and anesthetics, on my minor child _____ whether or not I am present at the actual appointment when the treatment is rendered. I further expressly agree to be financially responsible for all treatment rendered to the above named child, I hereby authorize payment directly to Two Rivers Dental Center from my insurance carrier for his services rendered. I have reviewed the plan of treatment and further authorize the above named dentist to release my information relating to a claim, including x-rays and study models.

FINANCIAL POLICY

As in the past, and as a courtesy to you, we will complete the forms necessary pertaining to your claim and submit them to your insurance carrier. We are not responsible for the amount or time that your insurance carrier takes to pay your claim. Our relationship is with you, the patient, not your insurance company. **You are responsible at the time of service for payment of any deductible, co-payment and estimated balance not payable by your insurance company. The remainder of the bill is to be paid within 60 days of the date of service with a 2% finance fee every 30 days.**

If you do not have insurance coverage, payment by cash, check, or credit card at the time of service is required.

Your appointment time in this office is reserved just for you, because you are important to us. We understand that incidents may arise which may make you unable to make your scheduled appointment, however, we ask that you give us at least a 24 – hour notice if you are unable to make your appointment. **After (2) two cancellations, without proper notification, you will be dismissed from our practice and charged a \$50.00 missed appointment fee.** Please help us avoid charging fees by keeping your appointments.

We gladly accept VISA, MASTERCARD, DISCOVER, AMERICAN EXPRESS & CARE CREDIT.

By signing this form, you have read the above policies and agree to abide by them.

Signature

Date

TWO RIVERS DENTAL CENTER, P.C.
51241 Hwy 6, Suite 5 - Glenwood Springs, CO. 81601
Phone (970) 945-2313 Fax (970)945-5505

DATE _____

Mr. Mrs. Miss Ms. Dr.

PATIENT NAME _____

DATE OF BIRTH _____ / _____ / _____
Last First Middle
SOCIAL SECURITY _____ - _____ - _____

MAILING ADDRESS _____ CITY _____ STATE _____

PHYSICAL ADDRESS _____ CITY _____ STATE _____

HOME PHONE #(_____) _____ Business Phone # (_____) _____

Cell Phone#(_____) _____ FAX # (_____) _____

E-MAIL ADDRESS _____

EMPLOYER _____

EMPLOYER ADDRESS _____

STUDENT - YES NO IF YES, NAME OF SCHOOL _____

WHO MAY WE THANK FOR REFERRING YOU? _____

WHO IS RESPONSIBLE FOR THIS ACCOUNT?

NAME _____ ADDRESS _____

RELATIONSHIP TO PATIENT _____

HOME PHONE # _____ BUSINESS PHONE # _____

EMPLOYER _____

INSURANCE INFORMATION

PRIMARY DENTAL INSURANCE CARRIER _____

INSURANCE ADDRESS _____

INSURANCE PHONE # _____

INSURED'S NAME _____ SS# _____

SUBSCRIBER EMPLOYER _____

GROUP # _____

EMERGENCY INFORMATION

Please list the names, addresses, phone numbers, and relationship to the patient of two friends or relatives in case of emergency.

1.) _____

2.) _____