

REGINALD PETTAWAY, D.D.S.

9850 Key West Avenue, Suite 308
Rockville, MD 20850
(301) 217-9700
DrReginaldPettaway.com

Información de Espos(a) responsable

Lo siguiente es para: Espos(a) del paciente La persona responsable para el pago

Nombre: _____ Hombre Mujer Casado Soltero Hijo Otro: _____

de Seguro Social: _____ Fecha de Cumpleaño: _____

Teléfono (Casa): _____ (Trabajo): _____ Ext: _____ Mejor hora para llamar: _____

Dirección: _____

Calle _____ Apartamento # _____

Ciudad: _____ Estate: _____ Código Postal: _____

Información de Empleo

Lo siguiente es para: Espos(a) del paciente La persona responsable para el pago

Nombre de Compañía: _____ Ocupación: _____

Dirección: _____

Calle _____ Apartamento # _____

Ciudad: _____ Estate: _____ Código Postal: _____

Información de Seguro

Primaria

Nombre de asegurado: _____ Esta asegurado el paciente? Si No

Apellido _____ Primer Nombre _____ Iniciales de segundo nombre _____

Cumpleaños de asegurado: _____ ID#: _____ Grupo/Plan #: _____

Dirección de asegurado: _____

Calle _____ Ciudad _____ Estado _____ Código Postal _____

Asegurado nombre de Compañía: _____

Dirección: _____

Calle _____ Ciudad _____ Estado _____ Código Postal _____

Relación con el asegurado y el paciente: Soy Yo Espos(a) Hijo(a) Otro _____

Plan/Dirección de seguro: _____

Segundaria

Nombre de asegurado: _____ Esta asegurado el paciente? Si No

Apellido _____ Primer Nombre _____ Iniciales de segundo nombre _____

Cumpleaños de asegurado: _____ ID#: _____ Grupo/Plan #: _____

Dirección de asegurado: _____

Calle _____ Ciudad _____ Estado _____ Código Postal _____

Nombre de Compañía/trabajo: _____

Dirección: _____

Calle _____ Ciudad _____ Estado _____ Código Postal _____

Relación con el asegurado y el paciente: Soy Yo Espos(a) Hijo(a) Otro _____

Nombre de plan y dirección de seguro: _____

Consent for Services / Consentimiento de Servicios

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me or at my request by the Doctor I agree to pay therefore the reasonable value of said services to said Doctor or his assignee at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to by me in writing within the time for payment thereof I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

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 understand and agree that as a courtesy to the doctor, staff, and other patients, 24 hour prior notice must be given in the event of canceling, and or rescheduling an appointment I further understand that if I fail to give proper notice a broken appointment charge will incur, to which I am responsible.

I have read the above conditions of treatment and payment and agree to their content.

Fecha: _____ Relación con el paciente: _____

Firma de Paciente, Padre o responsable _____

Fecha: _____ Relación con el paciente: _____

Firma del responsable de la cuenta (quien paga) _____