Dwaine E. Valentine, D.D.S., Inc.

Patient Name_____ _____ ____ D.O.B._____
First Last MI

Address_____ _____ _____ _____
Street City State Zip

Sex: M F Email Address_____ SS#_____

Home Phone (_____)_____Cell (_____)_____

Employer _____Spouse's Employer _____
(Parent if Minor) (Other Parent if Minor)

Emergency Contact _____ (_____)_____
Name Phone number

Who may we thank for referring you? _____

Dental Insurance Information (Primary)	Dental Insurance Information (Secondary)
Insured's Name	Insured's Name
Insured's Employer	Insured's Employer
Insurance Co.	Insurance Co.
Insured's SS#	Insured's SS#
Insured's DOB	Insured's DOB

Financial Agreement

Treatment recommendations are based on your health not your insurance or lack thereof. If you have insurance, it is your responsibility to be aware of what your benefits are. Your benefits are a contract between you and your insurance company. We will provide you with an estimate of benefits; however you are fully responsible for what your insurance will or will not cover.

We collect co-pays at the time of service. Outstanding balances will be billed to you after your claim has been processed by your insurance company. If payment is not received 60 days after the date of service, the patient will be responsible for payment of reasonable costs of collection, reasonable costs of attorney's fees, and court costs associated with the recovery of the monies due on the account.
Please let Jeanie know if any of your insurance information changes prior to or at your appointment.

My signature below indicates that I have read and agree to the above written financial policy of Dwaine E. Valentine, D.D.S., Inc.

Signature _____ Date_____