REGINALD PETTAWAY, D.D.S.
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Rockville, MD 20850
(301) 217-9700
DrReginaldPettaway.com

Spouse or Responsible Party Information

The following is for: ☐the patient's spouse ☐the person responsible for payment

Name:______________________ ☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other:__________

Social Security#:______________ Birth Date:______________

Phone (Home):______________ (Work):__________Ext:_____ Best time to call:______________

Address:____

Street Apartment#

City:______________State:______________Zip Code:______________

Employment Information

The following is for: ☐the patient's spouse ☐the person responsible for payment

Employer Name:______________ Occupation:______________

Address:____

Street Apartment#

City:______________State:______________Zip Code:______________

Insurance Information

Primary

Name of insured:______________________________Is insured a patient? ☐Yes ☐No

Last First MI

Insured's Birth Date:______________ ID#:______________ Group #:______________

Insured's Address:____

Street City State Zip Code

Insured's Employer Name:____

Address:____

Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other______________

Insurance Plan Name and Address:____

____

Secondary

Name of insured:______________________________Is insured a patient? ☐Yes ☐No

Last First MI

Insured's Birth Date:______________ ID#:______________ Group #:______________

Insured's Address:____

Street City State Zip Code

Insured's Employer Name:____

Address:____

Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other______________

Insurance Plan Name and Address:____

Consent for Services

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.

______________________________ Date:__________ Relationship to Patient: ______________

Signature of patient, parent or guardian

______________________________ Date:__________ Relationship to Patient: ______________

Signature of guarantor of payment/responsible party