MARTY J. SALTZMAN, DDS

Specialist in Endodontics & Dental Implants

Welcome to our office. We appreciate the confidence that your dentist has placed in us by referring you for endodontic treatment. Our goal is to provide you with the highest quality endodontic therapy in a painless and professional manner. Please complete this form. *Thank You.*

PATIENT INFORMATION (Age 18 & over)

Home Phone: _____
Full Legal Name:_____ Work Phone:_____
Address:_____ Cell Phone:_____
City/State:_____ Zip Code:_____
Soc. Sec#:_____ Date of Birth:_____ Sex: M F (circle)
Employer:_____ Occupation:_____
Who should we contact in case of emergency?_____ Phone:_____
Name of General Dentist:_____ Phone:_____
Who should we thank for this referral? (If other than your dentist)_____

PATIENT INFORMATION (If Under 18)

Patient Name:_____ Date of Birth:_____
Soc. Sec#:_____

DENTAL INSURANCE INFORMATION

Name of Insured:_____ Date of Birth:_____
Employer:_____ Soc. Sec. #:_____
Insurance Co.:_____ Group#:_____
Ins. Co. Phone#:_____ ID#:_____

FINANCIAL POLICY

We believe that patients appreciate being informed of our payment policy prior to treatment. Please feel free to discuss the treatment or fee at any time. Our policy is **PAYMENT AS SERVICES ARE RENDERED.** If treatment requires additional visits, your out-of-pocket portion is expected on the first visit.

As a courtesy to you, insurance forms will be filed for you. However, your insurance is a contract between you and your insurance company. **The ultimate responsibility for payment is with the patient/responsible party.** Our office allows 30 days for reimbursement. After 30 days any remaining balance is due **regardless of the status of the insurance claim**. A bill will be mailed and you will have 14 days to pay the balance in full or be subject to a $25.00 delinquent fee and 18% interest per year. If your account is sent to a collection service/attorney, you will be charged all processing fees, collection/attorney fees, court costs, interest, and late fees allowed by law. **Insurance companies frequently reimburse at a lower rate than we estimate. When this occurs you may be required to pay an additional "after insurance" balance.**

Estimated treatment fee:$_____** **Estimated portion due today:$_____

Method of Payment: **(please check one)**

__ Cash
__ Debit Card
__ Visa/Mastercard/Discover
__ Check *(Post-dated checks are not accepted.)*
__ Interest Free Financing
__ Partners

I have read and understand the financial policy. I authorize my insurance company to issue the dental benefits directly to this dental office. I acknowledge receiving the notice of Privacy Practices and consent to the use and disclosure of health information to carry out treatment, payment activities, and healthcare operations.

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Signature of Patient or Responsible Party Date