Anthony B. Rainwater, D.D.S., MS

PATIENT INFORMATION

Patient Name _____

Address _____ Cell Phone # _____

City _____ State ____ Zip _____ Home Phone# _____

Date of Birth _____ SS# _____ Work Phone# _____

Email Address: _____

Employer _____

General Dentist _____ Referred By _____

Emergency Contact Name _____ Emergency Contact # _____

FINANCIALLY RESPONSIBLE PERSON

Responsible Person _____ Relationship _____

Address _____ Cell Phone # _____

City _____ State _____ Zip _____ Home Phone# _____

Date of Birth _____ SS# _____ Work Phone# _____

Employer _____

DENTAL INSURANCE INFORMATION (IF APPLICABLE)

Insurance Company _____

Address _____

Policy/Group # _____ ID# or SS# _____

Secondary Insurance _____ ID# or SS# _____

Address _____

METHOD OF PAYMENT (CIRCLE ONE)

CASH CHECK CARE CREDIT VISA MASTERCARD DISCOVER AMEX

I understand that my insurance will be filed as a courtesy to me and all fees not covered by insurance are due at the time services are rendered. No balance shall be carried by Dr. Rainwater's office for more that SIXTY (60) days after insurance has been filed.

Our fees are based on the quality materials we use and the time, effort and skill required in performing your needed treatment. We charge what is the usual and customary for our area. We will assist you with your benefit eligibility before treatment to help you calculate your costs and maximize your insurance.

You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. We are happy to submit the claims necessary to see that you receive the full benefits of your coverage however we cannot guarantee any estimated coverage. Because the insurance policy is an agreement between you and insurance company, we ask that all patients be directly responsible for all charges. Please know that we will do everything possible to see that you receive the full benefits of your policy by electronically filing your claim the day of your appointment.

Our office NSF (Non-Suffiient Funds) policy fee is $25.00.

I authorize the release of any information including the diagnosis and the records of any examination and/or treatments rendered, to any other health care providers, such as my dentist or physician, who may be involved in my care.

Patient/Guardian _____ Date _____