Don A. Stoiber, DDS, SC

Account Registration

Account Holder: ______________________
Address: ______________________
City, State, Zip: ______________________
Home Phone: ______________________
Work Phone: ______________________
Cell Phone: ______________________
Birthdate: ______________________
Sex: ______________________
Social Security Number : ______________
Employer: ______________________

Dental Insurance Carrier: ______________
Address: ______________________
City, State, Zip: ______________________
Group #: ______________________
Subscriber #: ______________________
Physician's Name: ______________________
Physician's Telephone #: ______________

Spouse: ______________________
Address: ______________________
City, State, Zip: ______________________
Home Phone: ______________________
Work Phone: ______________________
Cell Phone: ______________________
Birthdate: ______________________
Sex: ______________________
Social Security Number: ______________
Employer: ______________________

Dental Insurance Carrier: ______________
Address: ______________________
City, State, Zip: ______________________
Group #: ______________________
Subscriber #: ______________________
Physician's Name: ______________________
Physician's Telephone #: ______________

Consent to Treatment

I hereby consent to dental treatment by Don A. Stoiber, DDS and his staff. I also authorize Don A. Stoiber, DDS, SC to furnish information to my dental insurance carrier(s) concerning my treatment and diagnosis.

Signature: ______________________________ Date: ____________________

Guardian's Signature (if under 18 yrs old): ______________________________

Assignment of Benefits and Payment Agreement

I hereby assign to Don A. Stoiber, DDS, SC all payments for dental services rendered to my dependents or myself. I understand that I am responsible for all fees regardless of insurance coverage. I understand that Don A. Stoiber, DDS, SC does **not** accept an insurance carrier's usual and customary fee as payment in full except when a contracted agreement has been signed with an individual carrier. I further understand that my account balance must be paid in full within 30 days of treatment, or my account may be subject to collection action. I agree that, if my account is turned over for collection, a **30%** administrative fee will be added to my outstanding balance.

Signature: ______________________________ Date: ____________________