

211 Storrs Rd. Mansfield, CT 06250

Dr. Karen E. Calef
(860) 456-3718

www.smilesbykaren.com

RESPONSIBLE PARTY FORM - ADULT

CONFIDENTIAL

Date: _____

PATIENT INFORMATION

Last Name: _____ **First :** _____ **M.I.:** _____ **E-mail** _____

Will enable you to receive e-mail reminder of appointments, access account and appointment info on-line through our secure website portal. You'll be able to log in using a user name & password.

Birthdate: _____ **Age:** _____ **Gender:** Male Female **S.S.N** _____

List order of preference for receiving calls: 1, 2, 3 in parentheses:

Phone # Home: (____) _____ () **Cell:** (____) _____ () **Work:** (____) _____ ()

Residence address: _____ **Years at this address:** _____

Mailing Address (if different): _____

I am: Single Married Widowed Separated Divorced

Occupation: _____ **Employer name /address:** _____ **Date employed** _____

Name of Spouse/closest relative: _____ **Home # (if different than yours):** (____) _____

Cell: (____) _____ **Work:** (____) _____ **Relationship to you:** _____

Address (if different than yours) _____

RESPONSIBLE PARTY INFORMATION **E-mail address:** _____

Who Is Financially Responsible For This Account? Last Name: _____ **First Name:** _____

Birthdate: _____ **Address:** _____

Years At This Address: _____ **If Less Than Five Years, Previous Address:** _____

S.S.N.: _____ **Phone # Home:** (____) _____ **Cell:** (____) _____ **Work:** (____) _____

Employer: _____ **Address:** _____ **Date Employed** _____

PATIENTS' INSURANCE INFORMATION

Insurance Coverage for Dental Treatment? yes no **Insurance Coverage for Orthodontic Treatment?** yes no

Subscribers Name: _____ **Relationship:** _____ **D.O.B.** _____

Employer Name: _____ **Address:** _____ **Date employed** _____

Insurance Company: _____ **Group #:** _____ **S.S.N:** _____

Insurance Company Address & phone#: _____

Secondary Policy Holder's Name: _____ **Relationship:** _____ **D.O.B** _____

Employer Name: _____ **Address:** _____ **Date employed** _____

Insurance Company: _____ **Group #:** _____ **S.S.N:** _____

Insurance Company Address & phone #: _____

How did you hear about our office? _____

Who suggested you may need orthodontic treatment? _____

"I hereby authorize DentalBanc, LLC, on behalf of Dr. Calef to obtain a copy of my credit report from a credit reporting agency for the purpose of considering payment options."

NOTE: "Obtaining a DentalBanc credit recommendation does not alter the responsible party's credit score in any way"

Signature: _____ **Printed name:** _____ **Date:** _____

If there is a charge for services, your signature below authorizes Dr. Karen Calef to bill your insurance company and make benefits payable to our office. Please be aware that you are responsible for the entire account, although we will be more than happy to process your insurance claims. We are third party to your insurance company and can only provide you with estimates. It is your responsibility to have knowledge of your insurance benefit including eligibility, maximums and deductibles.

The undersigned hereby promises to pay for all services rendered by Dr. Karen Calefs office. On default of any payment due the undersigned further agrees to pay the cost of collection, including reasonable Attorney's fees and court costs. Appointments cancelled or failed without 24 hours advanced notice are subject to charge.

Signature of responsible party: _____ **Date:** _____