Dr. Karen E. Calef
211 Storrs Rd. Mansfield, CT 06250 **(860) 456-3718** **www.smilesbykaren.com**

RESPONSIBLE PARTY FORM FOR PATIENTS UNDER 18 YEARS OF AGE

CONFIDENTIAL

Date: _____

PATIENT INFORMATION

Patient's Last Name: _____ First Name: _____ Prefers To Be Called:_____
Birth Date: _____ Age: _____ Gender: ☐Male ☐Female Home Phone #: (_____) _____
Patient's Mailing Address:_____
Residence address (if different): _____
Who Does Patient Live With? _____Grade: _____ Attends School At _____

CUSTODIAL PARENT INFORMATION

Custodial Parent(s) or Guardian(s): _____
Address (if different than patient's): _____
E-mail Address: _____
Preference for receiving calls: 1, 2, 3 in parentheses:
Phone # Home: (_____)_____( ) Cell: (_____)_____( ) Work: (_____)_____-_____( )

RESPONSIBLE PARTY INFORMATION E-Mail address:_____

Who Is Financially Responsible For This Account? Last Name: _____ First Name: _____
DOB:_____Address:_____
Years At This Address: _____ If Less Than Five Years, Previous Address: _____
S.S.N: _____ Phone # Home: (____)_____Cell: (____)_____Work: (____)_____
Employer: _____ _____ Date Employed: _____

PATIENT'S 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 your child 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: _____

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 Calef's 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: _____