Dr. Karen E. Calef
211 Storrs Rd. Mansfield, CT 06250 **(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: _____