Wayne County Dental Associates LLC

Robert Williams DDS

Patient: _____ Social Security #: _____
First Name Middle Initial Last Name

Date of Birth: _____ Sex: M F Marital Status: S M W D Other (circle one)

Mailing Address: _____

City:_____ State:_____ Zip: _____

Parent or Legal Guardian, please print:_____ Date of Birth: _____

Mailing Address (if different): _____

Cell #: _____ Landline #: _____ Work #: _____

Email (for appointment reminders): _____

☐ check if Robert D Williams DDS/Wayne County Dental Associates, LLC may NOT text you

Level of care you are interested in (mark 1): ___ Complete, including regular cleanings ___ Problem focused

School: _____ Grade/Year: _____

Nearest Relative Not Living With You: _____

Relationship to you: _____ Relative's #: _____

Physician's Name:_____ Phone #: _____

Insurance Information – Please complete all fields, insurance not documented completely may not be billed

Primary Ins Co: _____	Secondary Ins Co: _____
Subscriber's Name: _____	Subscriber's Name: _____
Subscriber's birthdate: _____	Subscriber's birthdate: _____
Subscriber's ID#: _____	Subscriber's ID#: _____
Subscriber's Employer: _____	Subscriber's Employer: _____
Relationship to Patient: _____	Relationship to Patient: _____
Subscriber's Address: _____	Subscriber's Address: _____
City: _____ State: _____ Zip: _____	City: _____ State: _____ Zip: _____
Subscriber's Phone: _____	Subscriber's Phone: _____

I understand that it is my responsibility to keep all contact information and insurance information up to date with Robert D Williams DDS/Wayne County Dental Associates, LLC . Insurance information provided after services are rendered may not be billed.

_____ _____

Signature of Parent or Legally Responsible Party Date

Wayne County Dental Associates LLC
Robert Williams DDS

Patient First & Last Name: _____Patient Date of Birth: _____

Assignment of Benefits: I hereby authorize payment directly to Robert D Williams DDS/Wayne County Dental Associates, LLC all health/dental insurance benefits otherwise payable to me by any third party reimburser applicable. I understand that I am financially responsible for charges not covered by this authorization. My Signature on this form will serve as a "signature on file" for processing claim forms. I authorize the release of any medical/dental or other information necessary to process my claims.

Collection Fee Responsibility Notice: In consideration of the services provided to the patient, the patient or responsible party herby guarantee payment in full of the patient's account in accordance with the financial arrangements made at the time of appointment or, if no such arrangements are made, then payment shall be made in full within thirty (30) days of appointment. The patient or responsible party agree that in the event of default in payment, reasonable costs of collection, equal to fifty (50) percent of the delinquent balance, and/or reasonable attorney fees may be added to the amount due on the account.

Statement Fee: Accounts that have received one with balance aged 90 days or greater may be assessed a $5 per monthly statement fee.

Returned Check Fee: There will be a minimum charge of $25 for any returned check.

Digital Signature: I understand and agree to the utilization of electronic document signing.

_____ _____
Signature of Parent or Legally Responsible Party Date

Release of Information and Treatment of Minors:

I authorize Robert D Williams DDS/Wayne County Dental Associates, LLC to release medical/dental and financial information about the above named patient to the following person/s. I authorize the following person/s to make medical/dental decisions about the above named patient. These people are in addition to the parent/legal guardian completing this paperwork.

_____	_____	_____
Name	Relationship to Patient	Phone Number
_____	_____	_____
Name	Relationship to Patient	Phone Number
_____	_____	_____
Name	Relationship to Patient	Phone Number
_____	_____	_____
Name	Relationship to Patient	Phone Number

This release shall remain in effect unless altered in writing.

_____ _____ _____
Signature of Parent or Legally Responsible Party Relationship to Patient Date