

Riverside Dental Health, Inc.
481 Hackensack Avenue
Hackensack, NJ 07602
201-488-8228

Today's Date _____

email address _____

PATIENT DATA

Name _____ Sex _____ SS# _____

Address _____

City _____ State _____ Zip _____

DOB _____ Home Phone _____ Cell Phone _____

Person Financially Responsible _____

Name of Insured _____ Work Phone _____

Name of Insurance Co. _____ ID# _____

Insured's SS# _____ Insured's DOB _____

Insured's Employer _____

Insurance
Address _____ Phone _____

FINANCIAL POLICY

We have a direct financial relationship with certain insurance companies. We will be happy to submit bills to these companies if you provide us with the necessary information. We would be pleased to help you with the details of your plans as best we can. However, with the myriad of different companies, we are not aware of all the specifics. It is your responsibility to know what your plan requires.

You are responsible at the time of your visit for all co-payment and deductibles determined by your insurance. The co-payment collected is an estimate only of the patient responsibility and may be adjusted based on the actual payment from your insurance carrier. Not all services are covered by all insurance plans. If the claim for your visit is rejected by your insurance company, you agree to be responsible for payments in full. If you do not have dental insurance you are responsible for payment at the time of service unless other arrangements are made in advance. A fee of \$33 will be added to the account for all returned checks. A surcharge will be added to any account turned over to a collection agency.

You agree to timely payment of all charges. You agree to provide accurate and up-to-date information concerning your dental plan and to notify us of any changes.

I have read this information and agree with my financial obligation.

Signed _____

Date _____

Patient Name _____