Abigail H. Mitchell, D.D.S., LLC

Avon Family Dentistry

ACCOUNT INFORMATION/ASSIGNMENT OF BENEFITS FORM

Please Print

Patient/Patients Name _____

DENTAL INSURANCE INFORMATION

(Primary Coverage)

Employee Name _____

Employee SSN _____- _____- _____ Employee DOB _____ / _____ / _____

Employer _____

Address _____

Insurance Company _____

Insurance Address _____

Insurance Phone _____

(Secondary Coverage)

Employee Name _____

Employee SSN _____ - _____ - _____ Employee DOB _____ / _____ / _____

Employer _____

Address _____

Insurance Company _____

Insurance Address _____

Insurance Phone _____

- I certify that all information provided regarding medical/dental histories and insurance benefits is accurate and complete.
- I authorize Avon Family Dentistry to release any records relating to my treatment to insurance companies and other health care providers.
- I authorize my insurance company to make direct payment to Avon Family Dentistry.
- I agree to remit all insurance deductibles and patient copayments when services are rendered.
- I agree to remit a $35.00 fee for the following: returned checks, missed appointments and for canceling appointments in less than 24 hours of my scheduled visit.
- I understand that I may be denied treatment (except in dental emergency situations) if my account becomes delinquent, in which case prepayment for services is required.
- In case of default of payment, I agree to pay collection fees and attorney fees that may accumulate up to 33%.
- All copayments are due at time of service. For children of divorce parents: the individual who brings the minor child to the office is responsible for the copayment at the time of service.
- I agree to remit payment for duplicating records and radiographs.
- By signing this agreement, I, _____, understand that I am responsible for all charges incurred on this account, and agree to pay all charges promptly when due.

Signature_____ Date _____

Relationship to Patient _____

Address _____

Phone (_____) _____ - _____ Work (_____) _____ - _____ Cell (_____) _____ - _____