

**Patient Information:**

Date: \_\_\_\_\_  
Name (Last, First, MI) \_\_\_\_\_

Married  Single  Minor  Male  Female

Address: \_\_\_\_\_  
Street Apt. # City State Zip

Birthdate: \_\_\_\_\_ Telephone: \_\_\_\_\_  
Month Day Year Home Work

Place of Employment (or School): \_\_\_\_\_ Grade: \_\_\_\_\_

S.S.N.# \_\_\_\_\_

Dental Insurance Co.: \_\_\_\_\_ Group / Plan #: \_\_\_\_\_

Has any other member of your family been treated in our office? \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

**Family Information**

Father (or Husband) Mother (or Wife)  
Name: Last First Middle Last First Middle

Address: \_\_\_\_\_  
Street City State Zip Street City State Zip

Telephone #: ( ) \_\_\_\_\_ ( ) \_\_\_\_\_  
Home Work Home Work

Birthdate / S.S.N. \_\_\_\_\_  
Month Day Year S.S.N. Month Day Year S.S.N.

Employer: \_\_\_\_\_  
Employer Employer

Dental Ins. Co.: Name \_\_\_\_\_ Name \_\_\_\_\_  
Group / Plan # Group / Plan #

Person Responsible For Your Dental Account:

Patient (self)  Father / Husband  Mother / Wife

Person to contact in case of emergency: Name \_\_\_\_\_ Tel # \_\_\_\_\_  
Last First MI

Address \_\_\_\_\_  
Street City State Zip

Dental Emergencies: We are available to our patients 24 hours a day. If you have an after hours emergency and you have been seen in our office in the last three years, please call our office number: (785) 843-9122. An after hours appointment fee will be charged if you have not been seen within the last three years in our office.

In order to help maintain a good relationship with our patients JayHawk Dental LLC has adopted a written financial policy. The purpose of this policy is to eliminate the confusion or misunderstanding concerning financial arrangements offered by our office. Our office communicates this policy to each patient.

For our patients with insurance benefits, please note that although we are happy to bill you insurance carrier as a courtesy, the insurance contract exists between the carrier and the insured. We will accept insurance assignment, but can not guarantee payment of benefits. Any questions regarding your benefits should be directed to your insurance carrier.

Payment at time of service is expected. The patient is expected to pay the estimated portion of their bill that the insurance will not cover when treatment is rendered. JayHawk Dental LLC accepts the following credit cards: Visa, MasterCard, and Discover. Payment with cash or check is always welcome.

JayHawk Dental LLC offers interest free 3, 6 and 12 month payment options with approved credit. Please inquire at the front desk for more details on these payment plans.

A statement of services rendered will be mailed at the end of each month. Receipt of payment is expected within 30 days from the time of service for any outstanding balance.

Your account will be considered delinquent if payment is not received within 60 days from the time of service; a late fee of 1.5% per month will be assessed and will appear on any subsequent statements. The annual percentage rate is 18%.

A \$35.00 charge will be billed to the patients account for any check returned by the bank for any reason not paid. We will resubmit the check for payment to the bank. However, if funds are still insufficient, we will not accept further payments by check in the future from the patient.

Delinquent accounts will be sent to a collection agency, and collection fees will be added to your account. If the balance is deemed uncollectible by the collection agency after 30 days, a report will be filed with the three major national credit reporting agencies, which will adversely affect your credit rating.

**Authorization:**

I have read and understand the financial policy of JayHawk Dental LLC and agree to all the terms described therein. I hereby authorize payment to JayHawk Dental LLC the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize JayHawk Dental LLC to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and my medical history ,are correct to the best of my knowledge.

Signature of Responsible Party:

\_\_\_\_\_

Date: \_\_\_\_\_