

# Don A. Stoiber, DDS, SC

## Account Registration

<b>Account Holder:</b> _____	<b>Spouse:</b> _____
Address: _____	Address: _____
City, State, Zip: _____	City, State, Zip: _____
Home Phone: _____	Home Phone: _____
Work Phone: _____	Work Phone: _____
Cell Phone: _____	Cell Phone: _____
Birthdate: _____	Birthdate: _____
Sex: _____	Sex: _____
Social Security Number : _____	Social Security Number: _____
Employer: _____	Employer: _____
Dental Insurance Carrier: _____	Dental Insurance Carrier: _____
Address: _____	Address: _____
City, State, Zip: _____	City, State, Zip: _____
Group #: _____	Group #: _____
Subscriber #: _____	Subscriber #: _____
Physician's Name: _____	Physician's Name: _____
Physician's Telephone #: _____	Physician's Telephone #: _____

## Consent to Treatment

I hereby consent to dental treatment by Don A. Stoiber, DDS and his staff. I also authorize Don A. Stoiber, DDS, SC to furnish information to my dental insurance carrier(s) concerning my treatment and diagnosis.

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

Guardian's Signature (if under 18 yrs old): \_\_\_\_\_

## Assignment of Benefits and Payment Agreement

I hereby assign to Don A. Stoiber, DDS, SC all payments for dental services rendered to my dependents or myself. I understand that I am responsible for all fees regardless of insurance coverage. I understand that Don A. Stoiber, DDS, SC does **not** accept an insurance carrier's usual and customary fee as payment in full except when a contracted agreement has been signed with an individual carrier. I further understand that my account balance must be paid in full within 30 days of treatment, or my account may be subject to collection action. I agree that, if my account is turned over for collection, a **30%** administrative fee will be added to my outstanding balance.

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