Smile Wright
DENTAL

General Dentistry for Children and Young Adults

Financial Responsibility Agreement

Patient Name: _____ Date: _____

I, (Print Parent/Guardian/Patient Name) _____ understand that Smile Wright Dental has cash or credit card only policy (no personal checks) and that payment is due at the time of service. I have been informed of the treatment plan and its associated fees. I realize that I am responsible for any remaining balance not paid by my dental benefit plan and agree to pay the balance at the time of service.

Parent/Guardian Signature _____ Date: _____

Primary Insurance

Name of Insurance: _____

Name of person carrying insurance: _____

SS# of Carrier: _____ Date of Birth of Carrier: _____

Does the patient have a secondary insurance? Y☐ N☐

If "Yes, please list: _____

Secondary Insurance

Name of Insurance: _____

Name of person carrying insurance: _____

SS# of Carrier: _____ Date of Birth of Carrier: _____

** Caresource, Medicaid, and all other state-funded insurances will not reimburse Smile Wright Dental for any remaining balance until services have been reimbursed by a patient's primary insurance first. It is pertinent that all primary and secondary insurance information is provided at all appointments in order to avoid parent being held responsible for payment.**