CONFIDENTIAL PATIENT INFORMATION AND AGREEMENT

GREGG A. HELVEY, D.D.S.
14 West Marshall Street
Middleburg VA 20118

Today's Date:_____/_____/_____

New Patient: _____Established Patient

PLEASE PRINT CLEARLY

Patient's Name: _____ Birth date: ___/__/___ Social Security #:_____Home Phone_____

Address: _____City: _____State:___ Zip: _____ Work or Cell#: _____

Place of Employment:_____Address:_____How Long:_____
Circle: (Patient Or Parent) (Company Name) (Company Address) (City, State)

If a student, Name of School or College: _____City: _____State: _____Zip:_____

Please check status: Single ____ Married ____ Divorced ____ Widowed ____

Responsible Person(s) Name: _____ Birthdates: __/__/__ Social Security #:_____Home phone: _____
(If patient a minor, under age 18)

Other Parent Name: _____ Birthdate: ____/____/___SS# _____

Account (physical) Address: _____ City: _____State: _____ Zip: _____

How long at this address? _____Home Phone: _____Work Phone:_____

Place of Employment:_____Address:_____How Long:_____
Circle: (Patient Or Parent) (Company Name) (Company Address) (City, State)

Mailing address other than home location: _____City: _____ State: ____Zip:_____
(PO Box)
Nearest Relative not living with you: Name: _____Home Phone:_____

Emergency Contact:_____ Home Phone: _____Work Phone:_____

Insurance Company:_____ Subscriber's Name:_____ Policy #: _____ Group #: _____

Address:_____ City:_____ State:_____ Zip: _____ Phone:_____

Secondary Insurance Company: _____ Subscriber's Name: _____Policy #:_____ Group #: _____

Address: _____City: _____State:_____ Zip: _____ Phone: _____

Whom may we thank for referring you to our office? _____

PATIENT AND RESPONSIBLE PARTY AUTHORIZATION

I authorize Gregg A. Helvey, DDS, Ltd., on behalf of _____to apply for benefits on my behalf for their covered services rendered and request that payments from the above named insurance company (ies) be paid directly to Gregg A. Helvey, D.D.S., L.T.D. for the treated person named. I certify that the information reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claim to the above named agent. I permit a copy of this authorization to be used in place of the original.

IN ALL CASES, PROFESSIONAL FEES ARE THE PATIENT, SPOUSE, GUARDIAN AND/OR PARENTS' RESPONSIBILITY.

Finance charge (no charge if paid in 30 days of billing date) is computed by a "Periodic Rate" of 1 ½ % per month, which is an ANNUAL PERCENTAGE RATE of 18% applied to the previous balance without deducting current payments and/or credits appearing on any given bill. Upon default in the payment of any bill the above rate will be charged on the unpaid balance at 1 ½% per month until the delinquency is paid. Patient and/or responsible party(ies) further agree to pay any and all collection fees incurred and legal expenses, including but not limited to Collection Agency and Attorney fees, all court related costs, service and filing fees, interrogatory and garnishment fees as well as any interest that may be adjudicated for the collection of past due debt on accounts for _____. A missed appointment not canceled with 24 hours notice will be billed for the time allowed and is not covered by insurance. Patient and other responsible party to sign below:

Print Name: _____ Signature: _____ Date: _____

Print Name: _____ Signature: _____ Date: _____

For Gregg A. Helvey, D.D.S., Ltd. _____Date: _____