PENSACOLA DENTAL CENTER
Thomas H. Pyritz, DDS, MAGD, CDT
8580 University Parkway, Pensacola, FL 32514
(850) 478-2998

Name _____ Sex _____ Birth Date _____
Last First Middle

Address _____ Phone (Home) _____ (Work) _____
Number Street
Address_____ (Cell) _____
City State Zip

Marital Status: Married ____ Single ____ Widowed ____ Divorced _____

Occupation: _____ Social Security Number _____

Employer: _____ If Full time Student, name of school _____

Business Address: _____
Number Street City State Zip

If patient is a minor, please give occupation, employer, business address of responsible parent in spaces above)

Spouse: Name _____ Employer _____
Name Address
Closest Relative Not living at home: _____ Telephone _____

Address:_____ Relationship _____

Referred By: _____

TERMS OF PAYMENT

1) Payment is expected at each visit.
2) If you are a comprehensive care patient and have dental insurance, we will bill the insurance company for payment on your behalf but expect payment for the deductible amount and any co-pay amount. If you are not a comprehensive care patient and have dental insurance, we ask that you pay up front and we will file your insurance to reimburse you.
3) Accounts not paid in full (as payments not paid by insurance company or delay in payment by insurance company) will be due upon receipt of monthly statement. Amounts not paid before the next billing date are subject to a monthly service charge of 1.5% (which is an annual percentage rate of 18%) applied to your unpaid balance.
4) The guarantor will be responsible for any penalties, legal costs or fees incurred for collection of accounts after 90 days past due.
5) A SERVICE CHARGE of $40 (forty dollars) will be added for returned checks.

I undertstand and agree to the terms of payment stated above.

Signed _____
Guarantor (person responsible for payment)

PLEASE FEEL FREE TO DISCUSS DENTAL FEES BEFORE TREATMENT IS GIVEN

********** If you have dental insurance, please continue to separate page **********