

**Stuart V. Corso, D.M.D.**  
**Child Registration and Payment Agreement**

Name of Minor/Child: \_\_\_\_\_ Nickname: \_\_\_\_\_  
Date of Birth \_\_\_/\_\_\_/\_\_\_ Male or Female Social Security # \_\_\_-\_\_\_-\_\_\_  
Mailing Address: \_\_\_\_\_  
Home Phone: \_\_\_\_\_

**Person Responsible for bill:**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_ E-Mail: \_\_\_\_\_  
Relationship to Minor/Child: \_\_\_\_\_

**Father/Guardian Name:** \_\_\_\_\_

Address: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_ E-Mail: \_\_\_\_\_

**Mother/Guardian Name:** \_\_\_\_\_

Address: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_ E-Mail: \_\_\_\_\_

**Dental Insurance:** \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Relationship to minor/child: \_\_\_\_\_  
Social Security or ID of Subscriber \_\_\_\_\_  
Birth Date of Subscriber \_\_\_/\_\_\_/\_\_\_  
Employer Name and Address \_\_\_\_\_  
Insurance Phone#: \_\_\_\_\_  
Group# \_\_\_\_\_

**I agree to pay all charges for dental services provided by this office to me and my family within 30 days from date of service. I understand that balances over 30 days will be charged 1% per month or a minimum billing charge of \$3.00 per month. This is equivalent to an APR of 12.7% or a minimal billing fee of \$36.00 per year. I hereby authorize payment directly to Stuart V. Corso, D.M.D. of any dental benefits payable to me as a result of services performed by this office. I authorize release of any information by Stuart V. Corso, D.M. D. as required by my dental insurance program for settlement of claims. In the event this account is placed with an attorney or other agent for collection, I agree to pay reasonable attorney fees, and other costs and fees of collection.**

Responsible Party Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Who may we thank for referring you? \_\_\_\_\_