

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

Patient Name: _____
Date of Birth ___/___/___ Male or Female Social Security# ___-___-___
Marital Status: Single Married Widowed Divorced
Home Phone: _____ Work Phone: _____
Cell Phone: _____ E-Mail: _____
Mailing Address: _____
Employer Name and Address _____
If full time student – Name of School _____
In Case of Emergency Contact _____ Phone _____

Person Responsible for bill:

Name: _____
Address: _____
Home Phone: _____ Work Phone: _____
Cell Phone: _____ E-Mail: _____

Dental Insurance:

Subscriber Name: _____ Relationship to patient _____
Social Security or ID of Subscriber _____
Birth Date of Subscriber ___/___/___
Employer Name and Address _____
Insurance Company 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.

Patient Signature: _____ Date _____
Responsible Party Signature: _____ Date _____

Who may we thank for referring you? _____