Guarantor Information

Please Print Date __________

Please tell us about the person who is financially responsible (guarantor) for this account.

Patients Full Name ____

Physical Street Address ____

Mailing Address (if different from above) __________________________

City/County _________________ State _________ Zip ____________

Home Phone _________________ SS# __________________________

Employer Name ____________________ Position __________________

Employer Phone ____________ Supervisor Name__________Years Employed_______

Spouse's Name ____________________ Spouse's SS# _______________

Spouse's Employer _________________ Position __________________

Spouse's Employer's Phone _____________________________________

COMMITMENT TO PAY

In the event Patient has Dental Insurance coverage, it shall be the sole responsibility of Patient to obtain benefit information from his/her insurance carrier for treatment provided to Patient. All employees of Dentistry by Design shall be held harmless by Patient for any inaccuracy or omission of information provided to this office by Patient's insurance carrier. Patient is responsible for all account balances remaining after final payment of insurance benefits and Patient shall be responsible for any/all expenses associated with the collection of their bill. A monthly finance charge of 1 1/2% will be applied to all balances over 30 days old. I certify that I have read and understand the above, and have truthfully answered all questions, including patient information, employment. I will not hold my dentist, or any other member of her staff, responsible for any errors or omissions that I my have made in the completion of this form. I hereby consent and authorize Dr. Vernon and the medical personnel of J. Keller Vernon, D.D.S., LTD. to perform any and all treatment for the patient herein as Dr. Vernon and/or medical personnel deem prudent and necessary in the dental care of said patient.

Dr. Vernon's office does request payment in full for your portion at the time of service. We only accept cash, personal checks, Visa, MasterCard and Care Credit. **You hereby authorize this office or it's agents to contact you at any of the telephone numbers listed on any and all forms ________.**
We welcome you to our family and look forward to helping you get the healthy, beautiful smile that you've always wanted. If there is anything we can do to make your visits here more pleasant, please don't hesitate to ask one of our staff members.

I have read, understand and accept the terms of the above outlined policies for insurance handling and financial commitments that I may incur as a result of treatment at Dr. Vernon's office.

Signature of Responsible Party ___________________________________

Date: ________________________