- UPDATE SHEET -

G. BARRY FRAZELLE, II, D.D.S. **CARTER W. LEE, D.D.S.**

SARAH E. PLESS, D.D.S.

1301 PHYSICIANS DRIVE • WILMINGTON, NORTH CAROLINA 28401

(910) 762-0958

❑ MARRIED ❑ SINGLE ❑ MALE ❑ FEMALE ❑ MINOR DATE: _____

NAME _____ SS # _____
LAST FIRST MI

ADDRESS _____ CITY _____ STATE _____ ZIP _____

BIRTHDATE _____ TELEPHONE _____
HOME WORK CELL

EMAIL ADDRESS _____

EMPLOYER _____ STUDENT/SCHOOL _____

DENTAL INSURANCE CO. _____ INSURED NAME _____

HAS ANY OTHER FAMILY MEMBER BEEN TREATED IN THIS OFFICE? YES NO WHO? _____

PERSON RESPONSIBLE FOR ACCOUNT: ☐ PATIENT

IF OTHER THAN PATIENT

NAME _____ RELATIONSHIP _____

ADDRESS / ST / ZIP _____ _____

TELEPHONE _____ _____

BIRTHDATE / SS# _____ _____

EMPLOYER _____ _____

PERSON OUTSIDE OF FAMILY TO CONTACT IN CASE OF EMERGENCY

NAME _____ TELEPHONE # _____
LAST FIRST MI

ADDRESS _____ CITY _____ STATE _____ ZIP _____

❑ Payment in full at each appointment by cash, check or bank card

❑ I elect to pay my deductible of $ _____ and any out-of-pocket portions as treatment progresses.

❑ On extensive treatment, I elect to pay 50% of my out-of-pocket portion on the preparation date and the balance on completion or deliver date.

FINANCE CHARGE. If I do not pay the entire New Balance within 25 days of the monthly billing date a FINANCE CHARGE will be added to the account for the current monthly billing period. The FINANCE CHARGE will be a periodic rate of 1.5% per month which is an ANNUAL PERCENTAGE RATE of 18% applied to last month's balance. In the case of default payment I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection on this account.

I hereby authorize payment directly to **Atlantic Dental Group** of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize **Atlantic Dental Group** to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history are correct to the best of my knowledge. I/we authorize **Atlantic Dental Group** to investigate my/our credit and employment history. I/we understand you will retain this information whether or not credit is approved.

X _____ DATE _____