

Drs. Noguera & Russo, P.C.
Diplomates, American Board of Endodontics

PERSONAL INFORMATION

Dr. _____
Mr. _____
Mrs./Ms. _____ Birthdate: _____

Street Address: _____

City, State, Zip: _____

Home Tel: _____ Cell: _____

E-mail: _____ SSN: _____

Employer: _____ Bus. Tel: _____

General Dentist: _____ Referred by: _____

Physician: _____ Tel: _____

Person to contact
in case of emergency: _____ Tel: _____

PAYMENT OPTIONS (circle one)

CHECK MC VISA DISCOVER AMEX CASH

FINANCIAL CONSENT

Payment is due when services are rendered, unless written arrangement is made in advance. If this account is placed in the hands of a collection agency or an attorney for collection, I agree to pay collection fees of thirty three and one-third percent (33.3%) of the unpaid principal and interest owing, plus all court costs and interest in the amount of one and one-half percent (1.5%) per month, beginning thirty (30) days after the monies have become due or expenses have occurred. Annual percentage rate is eighteen percent (18%). I further agree to pay returned check charges of \$25.00 per returned check.

Patient Signature (Parent or Guardian if patient is a minor)

Date