CHERRY Oral & Maxillofacial Surgery

Bradley A. Cherry, D.D.S., M.D.

Patient Information

Date: / /

Patient Name: [ ] Male [ ] Female

Address: City: State: Zip:

Phone: [H] ( ) - [M] ( ) - [W] ( ) -

Email: May We Contact You Via Email: [ ] Yes [ ] No

Patient's Social Security Number: - - Date of Birth: / /

Emergency Contact: Relation:

If a child, Parent/Legal Guardian's Name:

Demographic Information

Spouse's Name:

[ ] Single [ ] Married [ ] Widowed [ ] Divorced [ ] Separated

Responsible Party

Person Responsible for Account: Employed By:

Name of Insured: Date of Birth: / /

Insured's Social Security Number: - -

Name of Insurance: Policy No: Group:

CHERRY Oral & Maxillofacial Surgery

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Written Financial Policy

Thank you for choosing Bradley A. Cherry D.D.S., M.D. Our primary mission is to deliver the most comprehensive surgical care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options

Cash, Check[4], Visa, MasterCard, American Express or Discover

NO INTEREST Payment Plans (2) from Citi Bank Card or Care Credit.

Allows you to pay 6 - 12 months interest free[1]

Convenient, low monthly payment plans[2] also available

No annual fees or prepayment penalties

Please note:
Prior to your treatment, please request a complete description of our planned treatment along with the potential complications that might arise. Bradley A. Cherry D.D.S., M.D., P.A. requires payment prior to the beginning of your treatment. If you choose to discontinue care before treatment is completed, your refund will be determined upon review of your care.

We are a fee for service office and such we do not accept medical/dental insurance as a form of payment; however as a courtesy to our patients we will file the insurance for you, exception include Medicare. Any insurance company negotiations and reimbursements are the ultimate responsibility of the patient. For patients with participating dental insurance[3] we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.

A fee of $50 is charged for patients who miss or cancel more than three times in a calendar year without a 24 hour notice.

Bradley A. Cherry D.D.S., M.D., P.A. charges $50 for returned checks.

Patient, Patent or Guardian Signature: _____ Date: / /

Patient Name: (Please Print) _____

1 If paid within the promotional period (please ask for further details). Otherwise, interest assessed from purchase date. Minimum monthly payment required.
2 Subject to credit approval
3 However, if we do not receive payment from your insurance carrier within 90 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.
4. If your check is returned for non-payment, the full amount of the returned check is expected plus $50.00 to comer the bank service charges of 5% of the value of the check, whichever is greater.(Pursuant to Federal Law)