Professional Center of Dental Care
433 N. Bolingbrook Dr.
Bolingbrook, IL 60440
630-759-4191

Patients with dental insurance:

I understand Professional Center of Dental Care will submit services to my dental insurance company.

I understand it is **my responsibility to** know the terms and conditions of my insurance policy.

I understand any balance on my account, after the insurance payment, is my responsibility.

I agree to pay that balance in a timely manner.

Patients without dental insurance:

I understand that payment is due at time of service.

_____

Patient Name

_____ ___/___/____

Signature of Patient Date

_____ ___/___/___

Signature of Responsible party if patient is a minor Date