## **Person Responsible for Account**

Name:					
Work phone #: ext.	Но	me phon	e#: -	_	
Billing Address:					
City	State	2	Zip		
Relationship to Patient:			_ •		
Social Security #:	Em	ployer:			
Drivers License #:					
Primary Insurance					
Dental Coverage Yes	No				
Insurance Co. Name:					
Address:					
Address:  City  Insurance Co. Phone #:	State Z	Zip			
ilisurance Co. Filone #					
Group #(Plan, Local, or Policy #):					
Insured's Name:		Rela	ation:		
Insured's Name:  Insured's birth date: Insured's birth date:Insured's birth date:	sured's ID7	#:			
Insured's Employer:					
Employer's Address:					
Employer's Address:City			_State	_ Zip	
Secondary Insurance					
Dental Coverage:Yes	N	lo			
Insurance Co. Name:					
Address:					
City		State	Zip _		_
Insurance Co. Phone #:	-				
Group #(Plan, Local, or Policy #):	:				_
Insured's Name: Insured's birth date:// In		Relat	ion:		
Insured's birth date: /_/ In	sured's ID	#:			<del>-</del>
Insured's Employer:					
Employer's Address:					
City		State	Zip		

If you are unable to keep your appointment, please provide 24 hours advance notice or you may be charged a \$50 broken appointment fee.