Person Responsible for Account

Name: ____

Work phone #:___-___-____ ext.___ Home phone #: ___-___-_____

Billing Address: _______________________________________

City_______________State________Zip__________

Relationship to Patient:_________________

Social Security #:____-____-_______ Employer:____________________

Drivers License #: ______________________

Primary Insurance

Dental Coverage _____Yes _____No

Insurance Co. Name: _____________________________________

Address:____

City__________________State___Zip________________

Insurance Co. Phone #:____-____-_____

Group #(Plan, Local, or Policy #): _____________________________

Insured's Name: __________________________Relation:_______________________

Insured's birth date:__/__/____Insured's ID#: _________________________

Insured's Employer: ____

Employer's Address: ____

City________________________State ____ Zip ____________

Secondary Insurance

Dental Coverage: _______Yes _______No

Insurance Co. Name: ____

Address: ____

City _________________________State ______ Zip __________

Insurance Co. Phone #: ____-____-______

Group #(Plan, Local, or Policy #): ________________________________

Insured's Name: _________________________Relation: _______________

Insured's birth date:__/__/____ Insured's ID#: ________________________

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.