

Patient Information:

Patient Name: _____

Patient Address: _____

Patient's Birth Date: _____ Social Security _____

Preferred Confirmation: Home _____ Call Cell _____ Text Cell _____

PLEASE CIRCLE YOUR PREFERENCE FOR CONFIRMATION

Responsible Party:

Name: _____ Relationship to Patient: _____

Address: _____

Phone _____

Primary Insurance Information:

Employer: _____ Is the policy holder the patient? _____

Policy Holder's Name: _____

Policy Holder's Address: _____

Policy Holder's Phone: _____ Group Number _____

Insurance Company: _____

Secondary Insurance Information:

Employer: _____ Relationship to the policy holder: _____

Policy Holder's Name: _____

Policy Holder's Address: _____

Policy Holder's Phone: _____ Group Number _____

Insurance Company: _____

I authorize my insurance company to pay the dentist all insurance benefits otherwise payable to me for services rendered. I am fully aware that if some reason insurance denies payment, all services rendered are my responsibility for payment. I understand that I am financially responsible for all charges and my balance regardless of insurance. I authorize the dentist to release all information necessary to secure payment of benefits.

Signature of Responsible Party: _____

Date: _____