

PATIENT INFORMATION

PLEASE PRINT

FIRST NAME - INITIAL - LAST NAME		SOC. SEC. NO.	BIRTHDATE	AGE
ADDRESS		CITY, STATE	ZIP CODE	SEX MALE FEM
FAMILY DENTIST	HOME PHONE	WORK PHONE	MARITAL STATUS	
FAMILY PHYSICIAN	OCCUPATION	EMPLOYER		

LEGAL GUARDIAN OF PATIENT

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INSURANCE INFORMATION

PLEASE PRINT

INSURANCE COMPANY NAME		INSURANCE CO. TELEPHONE #	GROUP NUMBER
INSURANCE COMPANY ADDRESS		CITY, STATE	INSURED'S EMPLOYER
INSURED'S NAME	RELATION	INSURED'S BIRTHDATE	INSURED'S SS #

INSURANCE IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY. We are not a party to this contract. We file insurance claims as a courtesy to our patients. We will not become involved in disputes between you and your insurance company regarding deductibles, co-pays, covered charges, etc., other than to supply the necessary factual information. However, please remember, YOU ARE RESPONSIBLE FOR THE TIMELY PAYMENT OF YOUR ACCOUNT.

LATE PAYMENT CHARGES ARE ADDED TO UNPAID ACCOUNTS.

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment directly to the dentist named of the insurance benefits otherwise payable to me.

(Signature of responsible party)

(Date)