PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT

NAME _____ SOC.SEC.# _____ DATE OF BIRTH _____
ADDRESS _____ PHONE# _____ WORK# _____
CELL# _____ PAGER# _____
CITY _____ STATE _____ ZIP _____ MARITAL STATUS _____

SPOUSE _____ SOC.SEC.# _____ DATE OF BIRTH _____
ADDRESS _____ PHONE# _____ WORK# _____
CELL# _____ PAGER# _____
CITY _____ STATE _____ ZIP _____

INSURANCE INFORMATION

PRIMARY INSURANCE _____ GROUP# _____
ADDRESS _____ PHONE# _____
CITY _____ STATE _____ ZIP _____
INSURED'S NAME _____ DATE OF BIRTH _____ ID# _____
EMPLOYERS NAME & ADDRESS _____

SECONDARY INSURANCE _____ GROUP# _____
ADDRESS _____ PHONE# _____
CITY _____ STATE _____ ZIP _____
INSURED'S NAME _____ DATE OF BIRTH _____ ID# _____
EMPLOYERS NAME & ADDRESS _____

PATIENTS ON THIS ACCOUNT

NAME _____ NICKNAME _____ D.O.B. _____ PHONE# _____
RESIDES WITH _____ RELATION TO ACCOUNT HOLDER _____

NAME _____ NICKNAME _____ D.O.B. _____ PHONE# _____
RESIDES WITH _____ RELATION TO ACCOUNT HOLDER _____

NAME _____ NICKNAME _____ D.O.B. _____ PHONE# _____
RESIDES WITH _____ RELATION TO ACCOUNT HOLDER _____

NAME _____ NICKNAME _____ D.O.B. _____ PHONE# _____
RESIDES WITH _____ RELATION TO ACCOUNT HOLDER _____

NAME _____ NICKNAME _____ D.O.B. _____ PHONE# _____
RESIDES WITH _____ RELATION TO ACCOUNT HOLDER _____

NAME _____ NICKNAME _____ D.O.B. _____ PHONE# _____
RESIDES WITH _____ RELATION TO ACCOUNT HOLDER _____

EMERGENCY CONTACT NAME _____ WORK# _____ HOME# _____
WHOM MAY THANK FOR REFERRING YOU? _____

ASSIGNMENT AND RELEASE

I understand that claims for dental services rendered may be submitted to my insurance carrier by the above named providers. I authorize payment directly to the above named group of dental providers, otherwise payable to me. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize release of any information relating to dental claims to my insurance company.

_____ _____ _____
RESPONSIBLE PARTY SIGNATURE RELATIONSHIP DATE