RESPONSIBLE PARTY

NAME________________________________ RELATIONSHIP TO PATIENT ______________

ADDRESS____ HOME PHONE ________________

EMPLOYER______________________________________ WORK PHONE ________________

DENTAL INSURANCE INFORMATION

NAME OF INSURED ____________________ RELATIONSHIP TO PATIENT____________________

BIRTHDATE____________ SOC. SEC # __________________ HOME PHONE ________________

ADDRESS __________________________________CITY___________ STATE _____ZIP _________

NAME OF EMPLOYER _____________________________ WORK PHONE ____________________

ADDRESS OF EMPLOYER _____________________CITY___________STATE____ZIP_________

INSURANCE CO.____________________GROUP #__________ UNION OR LOCAL_____________

INSURANCE CO. ADDRESS_____________________CITY___________STATE____ZIP_________

*If you have additional insurance, please complete the following:

NAME OF INSURED__________________RELATIONSHIP TO PATIENT ____________________

BIRTHDATE______________SOC. SEC. #_______________HOME PHONE ____________________

ADDRESS____________________________________CITY________STATE____ZIP__________

NAME OF EMPLOYER_________________________ WORK PHONE________________________

ADDRESS OF EMPLOYER______________________ CITY ________STATE_____ZIP ________

INSURANCE CO.____________________GROUP#___________ UNION OR LOCAL___________

INSURANCE CO. ADDRESS_____________________CITY________STATE _____ ZIP_________

INSURANCE AUTHORIZATION – SIGNATURE ON FILE

I hereby authorize my health care provider to affix my name to all insurance submissions, documents, and/or information requested by my insurance company (s) relating to any and all health benefits due to me and my dependents.
I also authorize payment of healthcare benefits otherwise payable to me, directly to my doctor as listed above.
I agree to be held responsible for all charges and services not paid by my insurance company.

________________________________ ____

Today's Date Signature of Patient or Insured