Responsible Party Information

Name _____ _____
Last First Middle Marital Status

Address _____
Street City State Zip

How Long at this address _____ Home Phone _____ Work Phone _____

Social Security # _____ Birth Date _____ Relationship to Patient _____

Employer _____ Address _____ No. Years Employed _____

Spouse's Name _____
Last First Middle

Social Security # _____ Birth Date _____ Relationship to Patient _____

Employer _____ Address _____ No. Years Employed _____

Dental Insurance

Insured's Name _____ Insured's Soc. Sec. # _____

Insurance Company _____ Group No. _____ Local No. _____

Insurance Co. Address _____

Do you have dual coverage? Yes ☐ No ☐ If yes:

Insured's Name _____ Insured's Soc. Sec. # _____

Insurance Company _____ Group No. _____ Local No. _____

Insurance Co. Address _____

Insured's Employer _____

Emergency Information

Name of nearest relative not living with you _____

Complete Address _____

Phone _____

I realize that my insurance benefits are only an estimate and that I am responsible for all costs not paid for by my insurance company. I consent that my signature may be kept on file for submittal of any insurance claim forms pertaining to my family's dental treatment. I understand that if for any reason I or my family are unable to keep our appointments, that 48 hr. advance notice must be given to avoid being charged for our appointment.

Signature (Parent's signature if minor) _____ Date _____

Updates (date & initial) _____ _____ _____ _____ _____