## ANGELA B. BATESON, DDS

## GENERAL DENTISTRY

1400 S. Main Street, Findlay, Ohio 45850 419-425-0303

Bates ondds.com

BatesonDentistry@gmail.com

PAI	RENT / R	RESPONS	SIBLE	PARTY	INFOR	RMATION
How I am related to the minor chil	d:   Mother	□Stepmother	□Father	□Stepfather	□Guardian	□Other
Name						<u>□Male</u> □Female
Home #						
Address	EET/ CITY-STATE-ZIP					Email
Responsible party's employer				Occupation_		
Address						
AddressSTRE	EET/ CITY-STATE-ZIP					
	DENT	AL INSU	JRAN(	CE INFO	RMATI	ON
PRIMARY INSURED						
Name of insured						
			ID#			Group #
Insured's address	EET/ CITY-STATE-ZIP					
					R060711	
Insured's employer address						
Patient's relationship to insured:	□ Child	□Other				
Name / address of insurance plan	1					
SECONDARY INSURED						
Name of insured						Is insured a patient? □Yes □No
Insured's birth date			ID#			Group #
Insured's address	EET/ CITY-STATE-ZIP					
Insured's employer name						
Insured's employer address						
Patient's relationship to insured:	☐ Child	□Other				
Name / address of insurance plan	1					
emergency dental treatment or ar carry dental insurance understan personally responsible for paymedays. I understand that when app work to discuss matters related to	ny dental treame d that all dental nt of all treatmer propriate, credit b this form or the	nt performed with treament provid nt. A service char pureau reports m minor child's den	hout prior filled is perforge of 21% pay be obtain tal treatmer	nancial arranger rmed directly fo per annum will b ned. I grant my	ments will be por the patient a se charged on	RE ANY TREATMENT IS RENDERED. A paid for at the time of service. Patients when that you or your repsonsible party a the unpaid balance of all accounts over 6 your office to telephone me at my home
I∕ SIGN	ATURE OF PATIENT O	OR RESPONSIBLE PAR	(TY			TODAY'S DATE