

PARENT / RESPONSIBLE PARTY INFORMATION

How I am related to the minor child: Mother Stepmother Father Stepfather Guardian Other _____

Name _____ Male Female

SS# _____ Birth date _____

Home # _____ Work/Ext # _____ Cell # _____ Best time to call _____

Address _____ Email _____
STREET/ CITY-STATE-ZIP

Responsible party's employer _____ Occupation _____

Address _____
STREET/ CITY-STATE-ZIP

DENTAL INSURANCE INFORMATION

PRIMARY INSURED

Name of insured _____ Is insured a patient? Yes No

Insured's birth date _____ ID # _____ Group # _____

Insured's address _____
STREET/ CITY-STATE-ZIP

Insured's employer name _____ R060711

Insured's employer address _____

Patient's relationship to insured: Child Other _____

Name / address of insurance plan _____

SECONDARY INSURED

Name of insured _____ Is insured a patient? Yes No

Insured's birth date _____ ID # _____ Group # _____

Insured's address _____
STREET/ CITY-STATE-ZIP

Insured's employer name _____

Insured's employer address _____

Patient's relationship to insured: Child Other _____

Name / address of insurance plan _____

FINANCIAL AGREEMENT. FINANCIAL ARRANGEMENTS WILL BE MADE WITH YOU BEFORE ANY TREATMENT IS RENDERED. All emergency dental treatment or any dental treatment performed without prior financial arrangements will be paid for at the time of service. Patients who carry dental insurance understand that all dental treatment provided is performed directly for the patient and that you or your responsible party are personally responsible for payment of all treatment. A service charge of 21% per annum will be charged on the unpaid balance of all accounts over 60 days. I understand that when appropriate, credit bureau reports may be obtained. I grant my permission to your office to telephone me at my home or work to discuss matters related to this form or the minor child's dental treatment.

SIGN HERE 

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

TODAY'S DATE