

Home Address: _____
Street/PO Box City State ZIP
Home Landline Phone: _____ Employer: _____
Work Phone: _____ Relationship to Patient: _____

PLEASE, TURN form OVER and COMPLETE ALL INFORMATION, SIGN AND DATE, THANKS

_____ **I have NO dental insurance to cover any of my dental treatment.**

Otherwise, complete information below.

DENTAL INSURANCE – PRIMARY INSURANCE

Full Name of Person Carrying Ins: _____
First M Initial Last

SS#: _____ Personal ID#: _____
Both of these numbers must be provided for us to file your insurance.

Birthdate: _____ Relationship to Patient: _____

Name of Employer Carrying Ins: _____

Dental Insurance Carrier: _____ Group Number: _____

Ins. Address: _____ Phone #: _____

DENTAL INSURANCE – SECONDARY INSURANCE

Full Name of Person Carrying Ins: _____
First M Initial Last

SS#: _____ Personal ID#: _____
Both of these numbers must be provided for us to file your insurance.

Birthdate: _____ Relationship to Patient: _____

Name of Employer Carrying Ins: _____

Dental Insurance Carrier: _____ Group Number: _____

Ins. Address: _____ Phone #: _____

I certify that I (the patient or parent/guardian of patient) have completed all information to the best of my knowledge. Regardless of any insurance, I am totally responsible for total balance of the account for all professional services performed on my behalf or dependent(s).

Signature of Patient (or parent/guardian, if minor)

Today's Date