Financial & Insurance Information

(the following information will be kept confidential for in-office use only)

Responsible Party

Name_____SS#_____DOB_____

Address_____ City_____ State___ Zip_____

Driver's License ID#_____ Exp_____ Issuing State_____

Authorization and Release

I, the above named responsible party, hereby agree to pay all charges submitted by this office for this account. I agree to pay all applicable co-payments, deductibles and any balances that are not payable by insurance. I understand that any balances over 30 days may be subject to a 2% handling charge and that a $20.00 late fee may apply. In case of default on payment of this account, I agree to pay collection costs and attorney fees incurred in attempting to collect on any future outstanding balances.

Signature _____ Date_____

Primary Dental Insurance (if applicable)

Insured's Name _____ Insured's SS#_____ DOB_____

Insured's Employer_____ (W) Telephone_____

Employer's Address_____

Insurance Company Name_____

Group# (Plan, Local or Policy#)_____ I.D.#(if applicable)_____

Insurance Company Address_____

Secondary Dental Insurance (if applicable)

Insured's Name _____ Insured's SS#_____ DOB_____

Insured's Employer_____ (W) Telephone_____

Employer's Address_____

Insurance Company Name_____

Group# (Plan, Local or Policy#)_____ I.D.#(if applicable)_____

Insurance Company Address_____

Authorization I authorize my insurance company to pay to the dentist all insurance benefits otherwise payable to me for services rendered and authorize the release of all information necessary.

Insured's Signature _____ Date_____