ACCOUNT / INSURANCE INFORMATION

ALL FIELDS ARE REQUIRED. ENTER LINE or N/A if does not apply

DO NOT ENTER "SAME"

Child(ren) First & Last Names_____

Parent #1 _____ Cell#_____ Other#_____

Address _____ **City & Zip** _____

Parent #1 _____ Cell#_____ Other#_____

Address _____ **City & Zip** _____

Email Address **for appt reminders** _____

IF YOUR GROUP NUMBER OR PLAN LEVEL CHANGED with same employer, without this info, claims may be denied

Delta Dental of CO requires a unique ID#. If you don't have this, we must have the insured's SS# to look it up.

PRIMARY DENTAL INS_____ Policy Holder Employer_____

Policy Holder Name: _____ Policy Holder DOB: _____

Policy Holder Social Security # or ID #_____ Ins Ph#:_____

SECOND DENTAL INS_____ Policy Holder Employer: _____

Policy Holder Name: _____ Policy Holder DOB: _____

Policy Holder Social Security # or ID #_____ Ins Ph#:_____

****

IF YOUR CHILD MAY HAVE DENTAL (EMBEDDED) IN THEIR MEDICAL PLAN, PROVIDE THAT INFORMATION BELOW.
IF YOUR CHILDRENS MEDICAL INSURANCE PROVIDES ANY DENTAL, WE ARE REQUIRED TO BILL THE MEDICAL PRIOR TO BILLING THE DENTAL INSURANCE.

*******DO YOUR CHILDREN HAVE KAISER MEDICAL?*** ***** If so, we need EACH Child's Kaiser ID# to determine if any dental coverage is provided. They sometimes offer basic Dental coverage.

Child name & Their Personal Kaiser ID: _____

*****Medical Insurance IF they may provide (Embedded) Pediatric Dental coverage and not listed above:**

Ins CO: _____; Policy Holder Name & DOB: _____

Policy ID# (or Insured SS#): _____Ins Ph#: _____

****

I understand that if I have not provided correct or full insurance information above, I will be responsible for the entire bill after services are rendered. If I am not the parent, by signing, I acknowledge that to the best of my ability, I have provided up to date information.

** **Your Signature** _____ Printed Name_____

Are you the: _____Parent _____ Patient _____ Grandparent/Aunt/Uncle _____ Friend/Other

Date _____