

**Please complete all applicable sections,
Sign and date**

Child(ren) First & Last Names _____

Parent #1 _____ Cell# _____ Other# _____

Address _____ **City & Zip** _____

Parent #2 _____ Cell# _____ Other# _____

Address _____ **City & Zip** _____

Email Address for appt reminders _____

******WE NEED DETAILS OF INSURANCE, Thank you.**

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#: _____

Policy Holder Address IF different from above: _____

SECOND DENTAL INS _____ Policy Holder Employer: _____

Policy Holder Name: _____ Policy Holder DOB: _____

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

Policy Holder Address IF different from above: _____

IF your child(ren) has (or may have) Dental as part of their Medical (Embedded), Please provide your medical ins info- they will be primary.

Medical Ins Name: _____ Policy Holder Name: _____

DOB: _____ ID# or 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, I have provided up to date information.

**** Your Signature** _____ Printed Name _____

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

Date _____