<u>PER OUR DOCTORS, THIS FORM MUST BE COMPLETED IN IT'S ENTIRETY AND IS REQURED TO BILL INSURANCE</u>

Child(ren) First & Last Names____

Parent #1 ________________________________ Cell#________________________ Other#_________________________

Address ____ **City & Zip** ___________________________________

Parent #2 ________________________________ Cell#________________________ Other#_________________________

Address ____ **City & Zip** ___________________________________

Email Address **for appt reminders** ____

<u>MOST Insurance companies require an ID#.</u>

<u>If you don't have the ID#, we MUST have the insured's SS# to look it up.</u>

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:____

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

Medical Ins Name:_____________________________ Policy Holder Name:______________________________________

DOB:________________ ID# or SS#:______________________________ Ins Ph#: _______________________________

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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 current information.

** **Your Signature** _______________________________________ Printed Name_________________________________

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

Date ______________________