PER OUR DOCTORS,

THIS FORM MUST BE COMPLETED IN IT'S ENTIRETY AND IS REQURED @ EACH VISIT TO BILL INSURANCE

ALL Child(ren) First & Last Names_____

Parent #1 _____ Cell#_____ Other#_____

Address _____ **City & Zip** _____

Parent #2 _____ Cell#_____ Other#_____

Address _____ **City & Zip** _____

Email Address _____

If you wish to Opt Out of receiving billing information by email and text, please speak with a team member.

MOST Insurances require an ID#. **If you don't have the ID#, we MUST have the insured's SS# to verify insurance.**

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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MEDICAID OR CHP+ (CIRCLE ONE) ***PROVIDE CHILD'S FULL LEGAL NAME***

CHILD'S NAME:_____ ID#: _____

CHILD'S NAME:_____ ID#: _____

CHILD'S NAME:_____ ID#: _____

CHILD'S NAME:_____ ID#: _____

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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 _____