

Responsible Party Information if Not Patient from Page 1

Name: _____ Male Female Married Single Other _____
Social Security #: _____ Driver's License #: _____ Birth Date: _____
Phone (Home): _____ (Work): _____ Ext: _____ Cell Number: _____
Address: _____
Street Apartment # City State Zip Code

Employment Information

The following is for: the patient the person responsible for payment
Employer Name: _____ Occupation: _____
Address: _____ Do you have dental insurance? _____
Street City State Zip Code

Dental Insurance Information

Primary Insured Person's Information:

Name: _____ Birth Date: _____ ID or SS#: _____
Last First MI
Address: _____
Street City State Zip Code
Employer Name & Address: _____ Group#: _____
Insurance Plan Name and Phone Number: _____

Secondary Insured Person's Information:

Name: _____ Birth Date _____ ID# _____
Last First MI
Address: _____
Street City State Zip Code
Employer Name & Address: _____ Group#: _____
Insurance Plan Name & Phone Number: _____

Consent for Services

In order for us to help prepare your insurance forms and assist in making collections from insurance companies to credit your account, we will need the following authorizations: I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan. I consent to your use and disclosure of my protected health information to carry out payment activities in connection with my claims.

I grant permission for your office to telephone me at home or my work to discuss matters related to this form and/or the Financial Agreement Form.

X _____
Signature of Responsible Party/Parent or Guardian

I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the Dental Office:

X _____
Signature of Responsible Party/Parent or Guardian