

DENTAL INSURANCE INFORMATION

NAME OF POLICY HOLDER _____

HOME PHONE # _____ WORK PHONE# _____

POLICY HOLDER SS# _____ BIRTH DATE _____

EMPLOYER _____

EMPLOYER ADDRESS _____ ZIP _____

NAME OF DENTAL INSURANCE CO. _____

ADDRESS _____ ZIP _____

INSURANCE CO. PHONE# _____

POLICY OR ID# _____ GROUP# _____

Is patient covered under another dental plan? Yes _____ No _____

If yes name and address of insurance co. _____

_____ Zip _____

ID# _____ Group# _____

Employer _____ Employer phone # _____

Employers address _____ Zip _____

FINANCIAL INFORMATION

PLEASE CHOOSE A METHOD OF PAYMENT

PLEASE BE ADVISED ALL ACCOUNT BALANCES OVER 60 DAYS INCUR
1.5% FINANCE FEES, PER MONTH.

CASH ___ CHECK ___ MC ___ VISA ___ DISCOVER ___ AMERICAN EXPRESS ___

SIGNATURE _____ DATE _____

This signature allows us to file your insurance for you. Also called "Signature on file."
This signature gives permission to transfer x-rays, charting & progress notes for myself
and family. Signer agrees to pay attorney and collection fees, if this account is placed in
bad debt collections.