Financial Information

Patient's Name:_____

Insured's Information

Insured's Name:_____Insured's Birthdate:_____

Insured's Social Security #:_____Relationship to patient:_____

Employer Name:_____Work Phone #:_____

ID #: _____

Primary Dental Insurance Information

Insurance Company:_____Insurance Phone #:_____

Group#:_____Effective Date:_____

Insur. Co. Address:_____

_____

_____

Electronic filing #:_____

Office Information (to be filled out by our office)

Maximum:_____ Deductible:_____Apply to preventive:_____

Sealants:_____Basic:_____

Major:_____Preventive:_____

Orthodontic coverage:_____Does Ded. Apply:_____

Frequencies

Exam: _____ Bitewings: _____

Prophy: _____ Panoramic: _____

Fluoride: _____

Verified by:_____Spoke with:_____

I certify that I have read and understand the attached financial policy of this office. I agree to be responsible for all charges incurred on this child for dental treatment.

_____ _____ _____

Signature of Parent or Guardian Relationship to patient Date