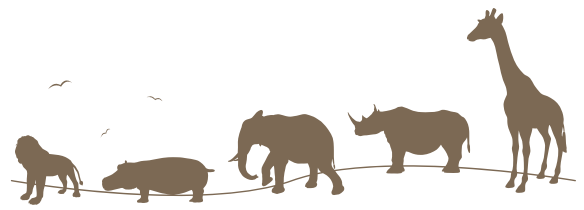


# ACCOUNT & INSURANCE INFORMATION



PATIENTS NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

BIRTHDATE: \_\_\_\_\_

## RESPONSIBLE PARTY

Name: \_\_\_\_\_

Relation: \_\_\_\_\_ SS#: \_\_\_\_\_

Billing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home #: ( ) \_\_\_\_\_ Email: \_\_\_\_\_

Employer: \_\_\_\_\_ Work #: ( ) \_\_\_\_\_

## PRIMARY DENTAL INSURANCE

Policy Owner: \_\_\_\_\_

Relation: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home #: ( ) \_\_\_\_\_

SS#: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Work #: ( ) \_\_\_\_\_ Ext: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Group #: \_\_\_\_\_

Plan #: \_\_\_\_\_

ID #: \_\_\_\_\_

## SECONDARY DENTAL INSURANCE

Policy Owner: \_\_\_\_\_

Relation: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home #: ( ) \_\_\_\_\_

SS#: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Work #: ( ) \_\_\_\_\_ Ext: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Group #: \_\_\_\_\_

Plan #: \_\_\_\_\_

ID #: \_\_\_\_\_