DENTAL ACCOUNT INFORMATION

**Please note that payment is due at the time of service*

Person Responsible for Account

Name: ____

Relationship: ____

Billing Address: ____

____

City *State* *Zip*

Cell #: ____

Work #: ____

Home #: ____

Email Address: ____

Primary Dental Insurance

Insurance Co. Name: ____

Insurance Co. Address: ____

____

City *State* *Zip*

Insurance Phone #: ____

Group # (Plan, Local, or Policy #): ____

Subscriber's Name: ____

Relationship to Patient: ____

Subscriber's Birthdate: ____

SSN/Scriber's #: ____

Subscriber's Employer: ____

**see back side for secondary insurance*

Secondary Dental Insurance

Insurance Co. Name: ____

Insurance Co. Address: ____

____

City *State* *Zip*

Insurance Phone #: ____

Group # (Plan, Local, or Policy #): ____

Subscriber's Name: ____

Relationship to Patient: ____

Subscriber's Birthdate: ____

SSN/Scriber's #: ____

Subscriber's Employer: ____