

Please complete the following information if the patient is a minor child

Mother's Name: _____

Mother's Address: _____

Mother's Home Phone Number: _____

Employer _____ Work Phone Number: _____

Mother's SS# _____ Date of Birth _____

Contact Email Address: _____

Father's Name: _____

Father's Address: _____

Father's Home Phone Number: _____

Employer _____ Work Phone Number: _____

Father's SS# _____ Date of Birth _____

Please complete the following information if you have dental insurance
(Note: All General Information must be completed)

Insurance Company Name and Address: _____

Employee / Subscriber Name and Address: _____

Employee / Subscriber SS# _____ Employee / Subscriber Birthdate: _____

Group Number: _____

Employer / Company Name and Address: _____

Patient Relationship to Employee (circle): Self Spouse Child Other

Is patient covered by another plan of benefits? yes no If yes, name and address of carrier:

Group Number: _____

Name and Address of Employer: _____

Employee / Subscriber Name: _____

Employee / Subscriber SS # _____ Employee / Subscriber Birthdate: _____

Employee Relationship to Patient (circle): Self Spouse Child Other

Please sign so that we may release information to your insurance company: _____

Please sign if you wish benefits to be paid directly to our office: _____