

PAYMENT BY: CASH _____ INSURANCE _____ DENTACARE _____ TITLE 19 _____ CONTRACT _____

ACCOUNT HOLDER:

SPOUSE:

If held, secondary dental insurance coverage must be listed.

NAME:

NAME:

ADDRESS:

ADDRESS:

CITY, STATE:

CITY, STATE:

ZIP CODE:

ZIP CODE:

HOME PHONE:

HOME PHONE:

WORK PHONE:

WORK PHONE:

PHONE OF NEAREST RELATIVE:

BIRTH DATE: / / SEX:

BIRTH DATE: / / SEX:

SOCIAL SEC. NO.:

SOCIAL SEC. NO.:

EMPLOYER:

EMPLOYER:

DENTAL INS. CO.

DENTAL INS. CO.

MAIL TO:

MAIL TO:

GROUP # OR LOCAL #

GROUP # OR LOCAL #

SUBSCRIBER #

SUBSCRIBER #

MEDICAL ASSIST. #

MEDICAL INSURANCE INFORMATION

PHYSICIAN'S NAME:

PHYSICIAN'S NAME:

TELEPHONE NO.:

TELEPHONE NO.:

MEDICAL INS. CO.:

MEDICAL INS. CO.:

MAIL TO:

MAIL TO:

GROUP #

GROUP #

SUBSCRIBER #

SUBSCRIBER #

I AUTHORIZE RELEASE OF ANY INFORMATION REQUIRED IN THE COURSE OF EXAMINATION AND/OR TREATMENT. I PERMIT PAYMENT OF INSURANCE BENEFITS DIRECTLY TO THE DENTIST FOR HIS SERVICES RENDERED. I RECOGNIZE AND ACCEPT RESPONSIBILITY FOR SERVICES NOT COVERED BY INSURANCE BENEFITS.

RESPONSIBLE PARTY SIGNATURE _____ DATE _____

PATIENT ACCOUNT REGISTRATION