CHILDREN'S DENTISTRY & ORTHODONTICS
WE MAKE SMILES

Dental Insurance Information

Primary Insurance Information

Policy holder name: _____

Policy holder SSN: _____

Employer: _____

Relationship to patient: ☐ Mother ☐ Father ☐ Stepparent ☐ Guardian

Insured Birth Date: _____

Ins. Company: _____

Ins. Address: _____

City, State, Zip: _____

Member or Alt #: _____

Group #: _____

Secondary Insurance Information

Policy holder name: _____

Policy holder SSN: _____

Employer: _____

Relationship to patient: ☐ Mother ☐ Father ☐ Stepparent ☐ Guardian

Insured Birth Date: _____

Ins. Company: _____

Ins. Address: _____

City, State, Zip: _____

Member or Alt #: _____

Group #: _____

Responsible/Financial Party Disclaimer: ** This refers to the individual who signs the medical consent form. If you have a custody/verbal arrangement where another person assumes all or partial financial responsibility for your child, Children's Dentistry & Orthodontics will **NOT seek payment on your behalf. It will be solely your responsibility to ensure that all or partial payments are made and accounted for. Initials: _____