Billing Information:

Person Responsible for Account______________________________ Sex: ____M ____F

SSN________________ Birthdate________________ Relation to Patient______________

Address (if different from patient's) ______________________________________

Employer____________________________ Home #____________ Work #____________

Primary Insurance:

Insured___________________________ SSN______________ Birthdate______________

Insurance Company____ Phone #______________

Address____ Group #______________

Employer____ Work #______________

Relation to Patient_____________________________

Secondary Insurance:

Insured___________________________ SSN______________ Birthdate______________

Insurance Company____ Phone #______________

Address____ Group #______________

Employer____ Work #______________

Relation to Patient_____________________________

Whom may we thank for referring you? ____

Person to contact in case of an emergency:_________________________ **Phone**____________

Authorization:

I authorize my insurance company to pay Rose City Dental Care all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize Rose City Dental Care to release all information necessary to secure the payment of benefits.

I understand that I am financially responsible for all services provided to me and/or my dependent(s), regardless of insurance payments.

I agree to pay all late and/or finance charges accrued on my account.

Signature____ Date________________

Payment is due in full at time of treatment unless prior arrangements have been approved.