RESPONSIBLE PARTY / INSURANCE INFORMATION

PRIMARY

Name of Responsible Party/ Insured: ____ Male _____ Female _____
Last First Mi

Relationship to Patient: Self ___ Spouse ___ Child ___ Other ______________________ Is Responsible Party/ Insured a Patient ☐ Yes ☐ No

Social Security # of Responsible Party/ Insured: __________________________ Birth date of Responsible Party/ Insured: ____________________________

Phone # Home: (_______)______________________ Business: (_______)__________________________ Other: (_______)__________________________

Address: ____
Street Apartment

____ DL# ____
City State Zip Code

Insurance Plan Name: ____ Phone # (_______)_____________________ Group # _______________________

Insurance Plan Address: ____
Street City State Zip Code

Insured's Employer: ____

Employer Address: ____
Street City State Zip Code

SECONDARY

Name of Responsible Party/ Insured: ____ Male _____ Female _____
Last First Mi

Relationship to Patient: Self ___ Spouse ___ Child ___ Other ______________________ Is Responsible Party/ Insured a Patient ☐ Yes ☐ No

Social Security # of Responsible Party/ Insured: __________________________ Birth date of Responsible Party/ Insured: ____________________________

Phone # Home: (_______)______________________ Business: (_______)__________________________ Other: (_______)__________________________

Address: ____
Street (If same as above please indicate) Apartment

____ DL# ____
City State Zip Code

Insurance Plan Name: ____ Phone # (_______)_____________________ Group # _______________________

Insurance Plan Address: ____
Street City State Zip Code

Insured's Employer: ____

Employer Address: ____
Street City State Zip Code

DENTAL MATERIALS FACT SHEET

I acknowledge that, upon request, I can receive a copy of the dental materials fact sheet.

Initial ______

HIPAA PRIVACY SHEET

I acknowledge that, upon request, I can receive a copy of the HIPAA privacy sheet.

Initial ______

AUTHORIZATION RELEASE AND AGREEMENT

I understand that I am responsible for payment of all services rendered on my behalf and on the behalf of my dependent(s).

I authorize Balfour Dental to release pertinent information to: ____

Relationship to patient: ____________________________________ Phone # ____

I understand in order to reserve my appointment exclusively with the doctor payment is due prior to the date of service.

I understand that I will be responsible for any fees charged to me for broken appointments or appointments canceled without 48 hours notice.

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such dental care to third party payers and / or other healthcare practitioners so that a claim for reimbursement can be filed on my behalf.

____ ______________________
Signature (Patient / Guarantor) Date