

1 RESPONSIBLE PARTY FOR BILLING (Insured/Parent) (If Different)

Responsible Party Name _____
 Responsible Party Address _____
 City _____ State _____ Zip _____
 Place of Employment _____
 Home Phone # _____ Business # _____
 Soc. Sec. # _____ Date of Birth _____ Marital Status _____

2 DENTAL INSURANCE

PRIMARY Ins. Carrier Name _____ Ins. Phone # _____
 Insurance Claim Center Address _____
 City _____ State _____ Zip _____
 Group # _____ Name of Policy Holder _____
 Relationship to Policy Holder _____ Birthdate of Policy Holder _____
 Employer _____ Policy Holder S.S. # _____

SECONDARY Ins. Carrier Name _____ Ins. Phone # _____
 Insurance Claim Center Address _____
 City _____ State _____ Zip _____
 Group # _____ Name of Policy Holder _____
 Relationship to Policy Holder _____ Birthdate of Policy Holder _____
 Employer _____ Policy Holder S.S. # _____

3 MEDICAL INSURANCE

PRIMARY Ins. Carrier Name _____ Ins. Phone # _____
 Insurance Claim Center Address _____
 City _____ State _____ Zip _____
 Group # _____ Name of Policy Holder _____
 Relationship to Policy Holder _____ Birthdate of Policy Holder _____
 Employer _____ Policy Holder S.S. # _____

SECONDARY Ins. Carrier Name _____ Ins. Phone # _____
 Insurance Claim Center Address _____
 City _____ State _____ Zip _____
 Group # _____ Name of Policy Holder _____
 Relationship to Policy Holder _____ Birthdate of Policy Holder _____
 Employer _____ Policy Holder S.S. # _____