

PATIENT PAYMENT INFORMATION FORM

FAMILY INFORMATION

Patient Name _____ Date of birth _____
Father's (or husband's) name _____ Position: _____
Address (if different from Patient): _____ Phone # (if different from Patient): _____
Employer name _____ How Long? _____ Business phone #: _____
Mother's (or wife's) name _____ Position: _____
Address (if different from Patient): _____ Phone # (if different from Patient): _____
Employer name _____ How Long? _____ Business phone #: _____

RESPONSIBLE PARTY INFORMATION

Name: _____
Single: _____ Married: _____ Divorced: _____ Widowed: _____ Other: _____
Residence: Address _____ City _____ State _____ Zip _____
Mailing Address: _____ City _____ State _____ Zip _____
of years at this address: _____ Phone (_____) _____ Bus phone (_____) _____
Social security #: _____ Birthdate: ____ / ____ / ____ Relationship to Patient: _____
Employer: _____ Position: _____ How long? _____
Spouse's name: _____
Employer: _____ Position: _____ How long? _____
Social security #: _____ Birthdate: ____ / ____ / ____ Relationship to Patient: _____

ORTHODONTIC INSURANCE INFORMATION

Insured's name: _____ Insured's soc. sec. # _____
Insurance company _____ Policy/Grp #: _____ ID#: _____
Insurance company address _____
Insurance company phone #: _____ Do you have dual insurance? Yes No
If yes, Insured's name: _____ Insured's soc. sec. # _____
Insurance company _____ Policy/Grp #: _____ ID#: _____
Insurance company address _____ Phone #: _____

EMERGENCY INFORMATION

Name of nearest relative not living with you: _____ Relationship: _____
Complete address: _____
Phone #: _____

Insurance information cannot be looked up unless the group ID# is provided. If the group ID# shown on your insurance card differs from your social security number, we will also need your social security number. Realize it may be appropriate to utilize a credit report in determining a payment plan.

Signature (parent's signature if minor) _____ Date: ____ / ____ / ____