CHILDREN'S DENTISTRY

PLEASE COMPLETE THE FOLLOWING INFORMATION
SO THAT WE MAY BILL YOUR DENTAL INSURANCE FOR YOU.

CHILD'S NAME _____ DATE OF BIRTH ____ / ____ / ____
ADDRESS _____
CITY _____ ZIP_____
HOME PHONE NUMBER _____

NAME OF DENTAL INSURANCE COMPANY _____ GROUP# _____
Is this a Cobra Plan?
CLAIM ADDRESS _____
INSURANCE PHONE NUMBER_____

CARDHOLDERS NAME (PRIMARY INSURANCE) _____
SS# _____ DATE OF BIRTH ____ / ____ / ____
ADDRESS _____
CITY _____ ZIP_____
HOME PHONE _____ WORK PHONE _____
EMPLOYER _____

NAME OF SECONDARY DENTAL INSURANCE _____ GROUP# _____
CLAIM ADDRESS _____
INSURANCE PHONE NUMBER_____

CARDHOLDERS NAME (SECONDARY INSURANCE) _____
SS# _____ DATE OF BIRTH ____ / ____ / ____
ADDRESS _____
CITY _____ ZIP_____
HOME PHONE _____WORK PHONE _____
EMPLOYER _____

I UNDERSTAND THERE WILL BE A CHARGE ASSESSED FOR FAILED/CANCELLED APPOINTMENTS WITH LESS THAN 24 HOURS NOTICE.

I authorize release of information to all my insurance carriers.
I understand that i am responsible for my bill.
I authorize payment directly to my dentist.
I permit a copy of this authorization to be used in place of the original.

SIGNATURE _____ DATE _____

CHILDREN'S DENTISTRY
A PARTNERSHIP

5150 WEST 80TH AVENUE WESTMINSTER, COLORADO
303-427-1951 Toll Free 1-877-427-1951