

LAKESIDE DENTAL CARE

RESPONSIBLE PARTY <i>Circle one:</i> MR MRS MS MISS DR	SECONDARY DENTAL INSURANCE
NAME:	SUBSCRIBER NAME:
ADDRESS:	ADDRESS:
CITY, STATE:	CITY, STATE:
ZIP CODE:	ZIP CODE:
HOME PHONE:	HOME PHONE:
WORK PHONE:	WORK PHONE:
PHONE OF NEAREST RELATIVE:	
BIRTH DATE: / / SEX: M F	BIRTH DATE: / / SEX: M F
SOCIAL SECURITY NO.: - -	SOCIAL SECURITY NO.: - -
EMPLOYER:	EMPLOYER:
DENTAL INSURANCE INFORMATION	SECONDARY DENTAL INSURANCE INFORMATION
INSURANCE NAME:	INSURANCE NAME:
INS. ADDRESS:	INS. ADDRESS:
GROUP # OR LOCAL #:	GROUP # OR LOCAL #:
SUBSCRIBER #:	SUBSCRIBER #:
TITLE 19 #:	TITLE 19 #:
MEDICAL INSURANCE INFORMATION	SECONDARY MEDICAL INSURANCE INFORMATION
INSURANCE NAME:	INSURANCE NAME:
INS. ADDRESS:	INS. ADDRESS:
GROUP #:	GROUP #:
SUBSCRIBER #:	SUBSCRIBER #:

Your insurance policy is a contract between you and your insurance company. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. Payment is due at time of service. We accept cash, checks, and most major credit cards.

Any missed appointments without 24 hour notice, except in emergency, will result in a charge to the patient. These charges are due and payable within 30 days.

I authorize release of any information required in the course of examination and/or treatment. I permit payment of insurance benefits directly to the dentist for services rendered. I recognize and accept responsibility for payment of services not covered by insurance benefits.

RESPONSIBLE PARTY SIGNATURE: _____ DATE: ____/____/____ STAFF: _____