Comprehensive Dentistry
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FINANCIAL AND INSURANCE QUESTIONNAIRE

Patient's Name: _____

Soc. Security #: _____

Date of Birth: _____

Responsible Party: _____ Relationship to Patient: _____

Soc. Security #: _____ Date of Birth: _____

Address: _____

Home Phone #: _____

Business Phone #: _____

Person Responsible for Insurance: _____

Employer: _____

Soc. Security #: _____ Date of Birth: _____

Dental Insurance Co.: _____

Address: _____ Phone #: _____

_____

Contract #: _____ Group #: _____ Subscriber #: _____

Is patient covered by additional dental insurance? Yes ____ No ____

If yes, subscriber's name: _____

Relation to patient: _____ Date of Birth: _____

Address: _____ Soc. Security #: _____

Subscriber Employed by: _____ Business Phone: _____

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I authorize the dentist to release all information necessary to secure payment of benefits. I understand that I am financially responsible for all charges, and that payment is due in full at the time of treatment, unless prior arrangements have been made.

Signature: _____ Date: _____