CREEKSIDE DENTAL

ACCOUNT/INSURANCE INFORMATION

PATIENT

Name_____

DOB _____ SSN _____

Is the patient the responsible party (circle one)? Yes (go to insurance info) / No

RESPONSIBLE PARTY

Name _____

DOB _____ SSN _____

Address (if different) _____

Phone: Home _____ Cell _____ Work _____

Email _____

INSURANCE INFORMATION

Subscriber Name _____

(If not listed above) DOB _____ SSN _____

Relationship to Patient: Self Spouse Parent Other:_____

Insurance Co Name/State _____

Phone _____

Subscriber/Member ID _____

Employer _____

Group Number _____

We bill participating insurance companies as a courtesy. ***You are expected to pay your deductible and co-payments at the time of service*.** If we have not received payment from your insurance company within 45 days of the date of service, you may be expected to pay the balance in full. You are responsible to be sure all charges are paid whether by you or by your insurance carrier.

RESPONSIBLE PARTY SIGNATURE _____

DATE _____