Moore Pediatric Dentistry

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BILLING AND FINANCIAL RESPONSIBILTY INFORMATION FOR PARENTS

Patient Name: _____

Father: _____ Date of Birth _____

First Middle Last

Mother: _____ Date of Birth _____

First Middle Last

Unmarried _____ Married _____ Divorced _____ Remarried _____

Residence Address: _____

Phone :_____Email:_____

Father's Information:

Employer:_____ Occupation: _____

Business Address: _____ Phone: _____

City: _____State: _____ Zip: _____ Cell: _____

Dental Insurance: _____ Group #: _____

Social Security #: _____ Driver's License #: _____

Mother's Information:

Employer:_____ Occupation: _____

Business Address: _____ Phone: _____

City: _____ State: _____ Zip: _____ Cell: _____

Dental Insurance: _____ Group #: _____

Social Security #: _____ Driver's License #: _____

Nearest Relative or Friend: _____ Relationship: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

Office has my permission to use computerized insurance forms: Yes _____ No _____

We will be happy to submit the appropriate forms to your insurance company or assist you in making financial arrangements, however, please understand that you have the final responsibility for all charges for services provided. I understand a $50.00 charge may be applied to my account for appointments cancelled without a 48hr notice and a monthly finance charge may be applied for balances that are over 30 days.

Signature: _____ Date: _____