Child Payment Information

Responsible Party and Insurance Information

The Following is for: ☐ the person responsible for payment ☐ the policy holder

Name: _____ Relationship to Patient: _____
Last First MI (Preferred Name)

Gender: _____ Family Status: _____ Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ (Cell): _____

Street Address: _____ City, State, Zip: _____

Email: _____

Dental Insurance Company: _____

Subscriber ID: _____ Insurance CO. Phone #: _____

Employer Name: _____