BILLING/RESPONSIBLE PARTY INFORMATION

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____

Other family members: _____

BILLING/RESPONSIBLE PARTY INFORMATION

Responsible Party Name: _____ Date of Birth: _____

SSN: _____ Relationship to Patient: ☐ Self ☐ Mother ☐ Father ☐ Other _____

Address: _____ City: _____ State: _____ Zip: _____

Best number to reach you during the day: _____ Email: _____

Employer: _____ Work Number: _____

Billing Party Name (IF DIFFERENT): _____ Date of Birth: _____

SSN: _____ Relationship to Patient: ☐ Self ☐ Mother ☐ Father ☐ Other _____

Address: _____ City: _____ State: _____ Zip: _____

Best number to reach you during the day: _____ Email: _____

Employer: _____ Work Phone: _____

DENTAL INSURANCE ☐N/A

1° Insurance Carrier: _____ Phone: _____ Employer: _____

Address: _____ City: _____ State: _____ Zip: _____

Insured Name: _____ Date of Birth: _____

Insurance ID#: _____ SSN: _____ Group #: _____

2° Insurance Carrier: _____ Phone: _____ Employer: _____

Address: _____ City: _____ State: _____ Zip: _____

Insured Name: _____ Date of Birth: _____

Insurance ID#: _____ SSN: _____ Group #: _____

Please complete the following if patient is a minor (under the age of 18)

Father's Name: _____ SSN: _____ Phone: _____

Mother's Name: _____ SSN: _____ Phone: _____

Patient living with: ☐ Mother ☐ Father ☐ Both ☐ Other _____

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Owen & Timock Orthodontics, PLLC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the release of all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: _____ Date: _____