CONFIDENTIAL RESPONSIBLE PARTY INFORMATION

A B C

Date_____ Patient Name_____ Birthdate_____

Legal Guardian/Responsible Party Name_____ Marital Status_____

Mailing address_____

How long at this address_____ Home Phone_____ Cell Phone_____

Previous address (if less than 3 yrs.)_____

E-Mail address_____ Work Phone_____

Social Security #_____ Birthdate_____ Relationship to Patient_____

Employer_____ Occupation_____ No. Yrs Employed_____

Other Legal Guardian_____ Relationship to Patient_____

Employer_____ Occupation_____ No. Yrs Employed_____

Social Security #_____ Birthdate_____ Cell Phone _____

INSURANCE INFORMATION

Primary Insured Name_____ Relationship to Patient_____

Employer_____ Birthdate_____

Insurance Co_____ Phone Number_____

Subscriber ID or SS#_____ Policy #_____ Group #_____

- I agree to be responsible for all charges for dental services and materials not paid by my dental insurance benefit plan, unless prohibited by law, treating dentist or dental practice has contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

Parent/Guardian Signature_____ Date_____

- I hereby authorize and direct payment of dental benefits otherwise payable to me, directly to Henry D. Browning IV, DDS, PA and/or Browning Orthodontics.

Parent/Guardian Signature_____ Date_____

EMERGENCY INFORMATION

Name of nearest relative not living with you_____

Phone_____ Relationship_____

- I understand that when appropriate, credit bureau reports may be obtained.

Guardian/Responsible Party Signature_____