PRIMARY DENTAL INSURANCE

Insured Party's Name _____

Relationship to Patient _____

Insured Address _____

City _____ State _____ Zip _____

Insured Home Phone: (_____) _____ Insured Work Phone: (_____) _____

Insured Date of Birth: _____ Sex: Male Female

Marital Status: Single Married Divorced Widowed

Insured Social Security # _____

Insured Employer: _____

Insurance Plan Name, Group #, and/or Contract #: _____

Insurance Co. Name & Address: _____

_____

Insurance Co. Phone & Fax _____

SECONDARY DENTAL INSURANCE

Insured Party's Name _____

Relationship to Patient _____

Insured Address _____

City _____ State _____ Zip _____

Insured Home Phone: (_____) _____ Insured Work Phone: (_____) _____

Insured Date of Birth: _____ Sex: Male Female

Marital Status: Single Married Divorced Widowed

Insured Social Security # _____

Insured Employer: _____

Insurance Plan Name, Group #, and/or Contract #: _____

Insurance Co. Name & Address: _____

_____

Insurance Co. Phone & Fax _____

CONSENT

I authorize & request my insurance company to pay Dental Care, LLC. directly, otherwise payable to me. I unconditionally agree to be responsible for and to pay Dental Care, LLC. for any & all charges incurred. I agree & understand that in the event I do not pay the balance due and my account is placed in the hands of a collection agency &/or Attorney for collection proceedings, I will be legally responsible for all Attorney fees, court costs, collection costs, consideration for assignment, litigation expenses, as well as any other incidental expenses incurred by Dental Care, LLC. &/or their assignees. I further understand a 1 1/2% finance charge (18% annually) for any balance over 90 days.

_____

Responsible Party (Must be 18 years or older) Date