Guarantor Form/Insurance Information:

Patient (s) Name: ___________________________ DOB:___________________

___________________________ DOB:___________________

______________________ _____ DOB:___________________

Responsible Parties' Information:

Father's Name:_________________________ **Mother's Name:**___________________________

Address:_______________________________ **Address:**_________________________________

______________________________________ ____

Occupation:__________________________ **Occupation:**______________________________

DOB: ______________________________ **DOB:** ___________________________________

Home #: __________________________ __ **Home #:**_________________________________

Work #:___________________________ __ **Work #:**_________________________________

Cell #:_____________________________ __ **Cell #:**__________________________________

Email:_______________________________ **Email:**__________________________________

PRIMARY DENTAL INSURANCE INFORMATION: *We will be happy to give you a super bill that you may mail to your secondary insurance company.*

Name of Policy Holder:_________________________ **DOB:**__________________________________

Insurance Company Name: ______________________ **Employer:**_____________________________

Social Security #:_______________________________ **ID #:**__________________________________

Group #:______________________________________ **Insurance Co. Phone #:**___________________

I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the dentists at Westfield Pediatric Dental Group as indicated on all submitted dental claim forms. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law or the treating dentist or dental practice has a 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.

________________________________ __________________________

Signature of Responsible Party Date