

APPLICATION				
Please print clearly. Must be completed in full for processing.				
APPLICANT INFORMATION				
Name of Account Holder:				
Male	Female	Date of Birth:	Social Security:	
Current address:				
City:	State:		ZIP Code:	
Work phone:	Cell Phone:	Home phone:		
Email:				
DENTAL INSURANCE INFORMATION				
Name of Primary Insurance Company:				
Claims address:			City:	
State:	ZIP Code:		Phone:	
Group #:				ID#:
Subscriber's name:			Male	Female
Date of birth:	Social Security:		Employer:	
Name of Secondary Insurance:				
Claims address:			City:	
State:	ZIP Code:		Phone:	
Group #:				ID#:
Subscriber's name:			Male	Female
Date of birth:	Social Security:		Employer:	
COVERED DEPENDENTS				
Name (Please provide name & location of college for full-time students)	Date of Birth	Male	Female	Relationship to subscriber
CREDIT CARD INFORMATION (NO FLEXIBLE SPENDING CARDS PLEASE)				
Account #	MC / VISA / DSCVR	Expiration Date & (3 digit v-code from back)		
All balances remaining after insurance payment or charges remaining unpaid 30 days from the original date of service (whichever comes first) will be billed to the credit card indicated above.				
***For patients also enrolled in auto-monthly ortho billing to their credit cards: Would you like us to bill this credit card for monthly ortho billing? YES NO				
Bill my monthly ortho separately on the card previously provided? YES NO				
Signature of Account Holder:				Date: