



Franklinton Dental Group

1531 W. Broad St.
Columbus, Oh 43222
(614) 351-0555



INSURANCE INFORMATION

Date _____
Patient Name _____
SSN # _____ Date of Birth _____
Sex: Male ___ Female ___
Marital Status: Single ___ Married ___
Student: Yes ___ No ___
If yes, where do you attend school? _____
Do you have physical or mental disabilities? Yes ___ No ___

Insurance Company _____
Policyholder Name _____ Date of Birth _____
Policyholder Social Security Number _____
Policyholder Employer _____
Employer Address _____

Employer Phone Number _____
Employment Status: Part time ___ Full time ___
Relationship to policyholder: Self ___ Spouse ___ Child ___
Other ___ please specify _____

Emergency Contact (*Not living with you*):

Name _____
Relation _____
Phone Number _____

As a courtesy to you, our office will bill your insurance company for services rendered. The patient is responsible for any deductible or co pay that applies. The deductible or co pay is due at the time services are rendered. Patient is also responsible for any portion that is not paid by the insurance company. Returned checks will be subject to an additional \$30.00 fee, and patient is responsible for all costs including cost of collection and attorney fees for any unpaid amount.

I understand that ultimately I am responsible for making sure that my bill is paid within 45 days from the time of service, regardless of insurance coverage.

Signature of responsible party _____ **Date** _____