JOHN BAIN DDS & CATHERINE AKRIDGE DDS

NATURAL FAMILY DENTISTRY

82 S Southwinds Road

Farmington, AR 72730

479-267-4900

Medical Insurance Information

Policy Holder:_____

Group #: _____

Employer:_____

Relationship to patient:_____

Social Security #:_____

Date of Birth: _____

Medical Insurance Co: _____

Phone:_____

Address: _____

Secondary Medical Insurance

Policy Holder: _____

Group #: _____

Employer: _____

Relationship: _____

Social Security#: _____

Date of Birth:_____

Secondary Insurance Co: _____

Phone: _____

Address: _____

Dental Insurance Information

Policy Holder: _____

Group #:_____

Employer: _____

Relationship to Patient:_____

Social Security #:_____

Date of Birth:_____

Dental Insurance Co: _____

Address:_____

Phone:_____

Secondary Dental Insurance

Policy Holder: _____

Group #: _____

Employer: _____

Relationship: _____

Social Security #: _____

Date of Birth: _____

Secondary Insurance Co:_____

Address: _____

Phone: _____

Financial Responsibility Statement

I am financially responsible for payment for the dental services rendered. Unpaid balances are subject to monthly statement preparation charges plus whatever expenses that occur in collection of fees due.

Signed: _____ **Date:** _____