

***Family & Aesthetic Dentistry of South Riding***

**Spouse or Responsible Party Information if not the Patient**

The following is for \_\_ Spouse \_\_ Person responsible for payment

Name: \_\_\_\_\_

( ) Male ( ) Female ( ) Married ( ) Single ( ) Child ( ) Other

Social Security # \_\_\_\_\_ Birth Date: \_\_\_\_\_

Phone ( Home) \_\_\_\_\_ (Work) \_\_\_\_\_ ( Other) \_\_\_\_\_

Address ( if different from patient information) \_\_\_\_\_  
Street Apartment

City State Zipcode

**Insurance Information**

Person Insured/Employee \_\_\_\_\_ Is insured a patient? ( ) Yes ( ) No  
Last First M.I.

Insured Date of Birth: \_\_\_\_\_ ID # \_\_\_\_\_ Group # \_\_\_\_\_

Insured Address: \_\_\_\_\_  
Street (if different from patient) City State Zipcode

Insurance Company Name and Address: \_\_\_\_\_  
\_\_\_\_\_

Insured Employer: \_\_\_\_\_

Patient's relationship to insured: ( ) Self ( ) Spouse ( ) Child ( ) Other \_\_\_\_\_