Westside Pediatric Dentistry, PLLC Dr. Thomas C. Burm, Jr. DMD Ph: 585-426-2550 Fax: 585-426-4118

BILLING INFORMATION: PLEASE PROVIDE DETAILED INFORMATION

Father ☐ Step-father ☐ Guardian ☐

Name: _____ **Birthdate:** _____**SS#:** _____

Address: _____ **City, ZIP:** _____

Home Phone: _____ **Cell phone:** _____ **Email:** _____

Employer: _____ **Work#:** _____

Mother ☐ Step-Mother ☐ Guardian ☐

Name: _____ **Birthdate:** _____**SS#**:_____

Home Phone _____ **Cell phone:** _____ **Email:** _____

Address: _____ **City, ZIP:** _____

Employer: _____ **Work #:** _____

PRIMARY DENTAL INSURANCE

Policy Holder: _____ **Relationship to child: Parent ☐ GrandParent ☐ StepParent ☐**

InsuranceCo.Name:_____ **Birthdate:** _____**Policy/ID #**_____

Subscriber Address (if different from above): _____ **City,State/ZIP:** _____

Employer (please indicate full name of employer instead of initials only):

_____ **Work #:** _____

ADDITIONAL DENTAL INSURANCE

Policy Holder: _____ **Relationship to child: Parent ☐ GrandParent ☐ StepParent ☐**

InsuranceCo.Name:_____ **Birthdate:** _____ **Policy/ID #**_____

Subscriber Address (if different from above): _____ **City,State/ZIP:** _____

Employer (please indicate full name of employer instead of initials only):

_____ **Work #:** _____

MEDICAL INSURANCE

Policy Holder: _____ **Relationship to child: Parent ☐ GrandParent ☐ StepParent ☐**

Insurance Co. Name: _____ **Birthdate:** _____ **Policy/ID#**:_____

Subscriber Address (if different from above): _____ **City,State/ZIP:** _____

Employer (please indicate full name of employer instead of initials only):

_____ **Work #:** _____

INSURANCE CONSENT:

I authorize the insurance company indicated to pay to the dentist all insurance benefits. Any payments received by the doctor from my insurance coverage will be credited to my account. I authorize the use of this signature on all insurance submissions.

Signature: _____

Date: _____