ROGUE VALLEY
FAMILY DENTISTRY

Responsible Party

Name of person responsible for this account:_____

Relationship to patient: _____

Address:_____City:_____State:_____Zip: _____

Home Phone#:_____Cell Phone#: _____

Birthdate:____/____/_____Soc.Sec.#_____

☐ Single ☐ Married ☐ Child

Driver's License#: _____

Employer:_____Work Phone: _____

Check your preferred method of payment.

☐ Cash ☐ Personal Check ☐ Credit Card ☐ I wish to discuss the Office's payment plan

Insurance information

Name of insured:_____Relationship to Patient: _____

Birthdate:____/____/_____Soc.Sec.#:_____Date Employed: _____

Name of Employer:_____Union or Local #:_____Phone #: _____

Insurance Company:_____Group#:_____Policy#: _____

Address:_____City:_____State:_____Zip: _____

Do you have any additional insurance? ☐ Yes ☐ No If yes, please complete the following:

Name of insured:_____Relationship to patient: _____

Birthdate:____/____/_____Soc.Sec.#:_____Date Employed: _____

Name of Employer:_____Union or Local#: _____

Work phone: _____