DENTISTRY "4" CHILDREN, LLP
Jeremy C. Wiggins, D.D.S.
Curtis E. Wiggins, D.D.S.
Children • Teenagers • Handicapped

For office use only

Patient _____

DOB _____ Acct # _____

Financial Information

Today's Date _____

Dental Care To Be Paid By: Please Show Receptionist Insurance Card

☐ Cash Payment ☐ Insurance/Co-Payment ☐ ID Medicaid ☐ WA Medical Assistance

Primary Insurance (this is the person whose name is imprinted on the Insurance I.D.Card)

Subscriber Name _____ Relationship to Patient _____

Date of Birth _____ Social Security # _____

Mailing Address _____ City _____

State _____ Zip _____

Name of Insurance Co. _____

Address of Insurance Co. _____ City _____

State _____ Zip _____

Group Number _____ Subscriber Number _____

Is Patient Covered By Any Other Insurance?

☐ No ☐ Yes-Complete Below

Secondary Insurance

Subscriber Name _____ Relationship to Patient _____

Date of Birth _____ Social Security # _____

Mailing Address _____ City _____

State _____ Zip _____

Name of Insurance Co. _____

Address of Insurance Co. _____ City _____

State _____ Zip _____

Group Number _____ Subscriber Number _____

Required Signature (Responsible Person)

I assume responsibility for payment of services at the current fees as they are rendered.

_____ _____

Responsible Person / Insured Person / or Legal Guardian Date