



M. Wendy Holder, D.M.D., P.C.
960 Airport Drive
Alexander City, AL 35010

Primary Dental Insurance

Responsible Party Information

Person Responsible for Account	<input type="text"/>	Relationship to Patient	<input type="text"/>
Birthdate	<input type="text"/>	SS#	<input type="text"/>
Home Phone	<input type="text"/>		
Mailing Address	<input type="text"/>		
City	<input type="text"/>	State	<input type="text"/>
Zip Code	<input type="text"/>		
Employer	<input type="text"/>	Occupation	<input type="text"/>
Mailing Address	<input type="text"/>	Business Phone	<input type="text"/>
Insurance Company	<input type="text"/>		
Subscriber I.D.#	<input type="text"/>	Group	<input type="text"/>

Assignment and Release

I hereby authorize payment directly to _____
for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize Dr. Holder, P.C and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party _____

Date _____