RONALD F. KONOPKA, D.D.S.

Dependent Patient Information

Date ________________________

Name ____________________________________ Birth date _________________ Soc. Sec. No. _______________________

Address_____________________________________ Phone Hm _______________ Cell ________________Wk _____________

City and Zip_____________________________________

Father's Name ______________________________Birth date_________________ Soc. Sec. No._______________________

Father Employed By__________________________________

Mother's Name _____________________________ Birth date _________________ Soc. Sec. No. ______________________

Mother Employed By __________________________________

Person Responsible for Account ____

Address (if different than above) ____

Dental Insurance

Father's ____

Mother's ____

I hereby authorize payment directly to the dentist of insurance benefits otherwise payable to me. I also authorize the dentist to release any information relating to this claim.

Signature ____