



Kelly Walk, D.D.S.
NJ Specialty Permit #6244

Myra Tariq, D.M.D.
NJ Specialty Permit #07265

Timothy P. McCabe, D.M.D.
NJ Specialty Permit #3983

Julie Jong, D.M.D.
NJ Specialty Permit #5478

Maria Shin, D.D.S.
NJ Specialty Permit #5254

Guarantor Form/DENTAL Insurance Information:

Patient (s) Name: _____ DOB: _____

DOB: _____

DOB: _____

Responsible Parties' Information:

Father's Name: _____ Mother's Name: _____

Address: _____

DOB: _____ DOB: _____

Cell #: _____ Cell #: _____

Primary Insurance Info: check if none

Name of Policy Holder: _____ Insurance Company Name: _____

Employer: _____ Social Security #: _____

ID #: _____ Group #: _____ Ins. Co. Phone #: _____

Mailing Address for Claims: _____

Secondary Insurance Info: check if none

Name of Policy Holder: _____ Insurance Company Name: _____

Employer: _____ Social Security #: _____

ID #: _____ Group #: _____ Ins. Co. Phone #: _____

Mailing Address for Claims: _____

I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the dentists at Westfield Pediatric Dental Group as indicated on all submitted dental claim forms. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

Signature of Responsible Party

Date