



832 Germantown Pike, Suite 1
Plymouth Meeting, PA 19462
OFFICE 610.277.0996
FAX 610.275.5075
plymouthvalleydental.com

Statement of Custodial Parent/Guardian

_____ is/are designated custodial parent for patient _____ and shall be provided with information as may be necessary to obtain benefits, including copies of benefit booklets, insurance contracts and claim information.

_____ Shall submit claims for covered services and direct the payment of these services to be sent to Robert L. Adelman, DMD Associates, Plymouth Valley Dental Group, at 832 Germantown Pike, Suite #1, Plymouth Meeting, PA.

In addition, if payment in full is not received from the insurance company, _____ agrees to be financially responsible for payment of any and all remaining balance.

Signature

Date