

Insurance Information:

Name of insured Subscriber: _____

Relation to patient: Self _____ Spouse _____ Other _____

Address: _____
Street and Apartment Number

City: _____ State: _____ Zip Code: _____

Home phone: (____) _____ Business phone: (____) _____

SS#: _____ - _____ - _____ Date of Birth: _____ / _____ / _____
Month Day Year

Employer: _____

Primary Dental Insurance:

Company _____ Insurance Phone#: (____) _____

Address: _____ Group #: _____

City: _____ State: _____ Zip: _____ ID# _____

Secondary Insurance:

Subscriber's Name: _____ SSN _____

Company _____ Insurance Phone #: (____) _____

Address: _____ Group #: _____

City: _____ State: _____ Zip: _____ ID# _____

I authorize the release of information relating to this claim. The dental office will pre-determine the insurance benefit for treatment, and will submit dental insurance forms as a courtesy to our patients. Insurance payments will be made directly to the insured. I understand that I am responsible for all costs of treatment, and that payment is due and payable according to financial agreements made with this office.

Signature: _____ Date: _____