

PRIMARY INSURANCE INFORMATION:



EMPLOYEE'S NAME:

FIRST

MIDDLE

LAST

SOCIAL SECURITY #

DATE OF BIRTH

EMPLOYER

INSURANCE COMPANY

HOME ADDRESS

STREET OR PO BOX

CITY

STATE

ZIP

HOME PHONE

WORK PHONE

RELATION OF INSURED TO PATIENT

Husband

Wife

Mother

Father

Other

POLICY NUMBER

OR

GROUP NUMBER

SECONDARY INSURANCE INFORMATION:

EMPLOYEE'S NAME:

FIRST

MIDDLE

LAST

SOCIAL SECURITY #

DATE OF BIRTH

EMPLOYER

INSURANCE COMPANY

HOME ADDRESS

STREET OR PO BOX

CITY

STATE

ZIP

HOME PHONE

WORK PHONE

RELATION OF INSURED TO PATIENT

Husband

Wife

Mother

Father

Other

POLICY NUMBER

OR

GROUP NUMBER

AUTHORIZATION:

ALL DEDUCTIBLES AND CO-PAYMENTS ARE DUE ON THE DATE SERVICE IS RENDERED.

I authorize release of any information relating to my insurance claims. I understand that I am responsible for all costs of dental treatment and that an 18% interest fee per month will be added to my account if I or my insurance company have not paid the reimbursement balance within a reasonable length of time.

SIGNED (PATIENT OR PARENT IF MINOR)

DATE

SIGNED (INSURED PERSON)

DATE